

EXHIBIT A

**IN THE STATE COURT OF FULTON COUNTY
STATE OF GEORGIA**

ROBERT A. COKER and)
SHERRI A. HUTSON, individually and)
SHERRI A. HUTSON as Executor of the)
Estates of BETTY J. COKER)
and ROBERT L. COKER,)

CIVIL ACTION

Plaintiffs,)

FILE NO. _____

v.)

KINDRED HEALTHCARE)
OPERATING, INC., KINDRED)
HEALTHCARE, INC., LAFAYETTE)
HEALTH CARE CENTER, INC., and)
SALLY GOZA, M.D.,)

**JURY TRIAL
HEREBY DEMANDED**

Defendants.)
 _____)

COMPLAINT FOR DAMAGES

COME NOW ROBERT A. COKER (hereinafter “Andy”) and SHERRI A. HUTSON, individually and SHERRI A. HUTSON, as Executor of the Estates of Betty J. Coker (hereinafter referred to as “Mrs. Coker”) and Robert L. Coker (hereinafter referred to as “Mr. Coker”), plaintiffs herein (hereinafter collectively “plaintiffs”), by and through undersigned counsel, and file this, their Complaint for Damages and show this Court as follows:

PARTIES & JURISDICTION

1.

This Honorable Court has jurisdiction of this action for damages resulting from personal injuries caused by the grossly negligent acts of the defendants.

2.

Robert A. Coker and Sherri A. Hutson are adults, of sound mind and bring this case individually in their own right and as the heirs and children of Betty J. Coker and Robert L. Coker, both deceased.

3.

Sherri A. Hutson also brings this case as the executor of the estates of Betty J. Coker and Robert L. Coker, including all rights as asserted hereunder. The Letters Testamentary from the Fayette County Probate Court demonstrating her authority to act in these capacities are found attached hereto as Attachment “5” and Attachment “6”.

4.

Although plaintiffs do not believe that they are required to file an O.C.G.A. § 9-11-9.2 Medical Authorization form but, in an excess of caution, a signed Medical Authorization form is attached hereto as Attachment “7”. The plaintiffs do not waive any rights they have (or Decedents had) under Federal HIPAA law by attaching this

authorization. Should anyone elect to use the Medical Authorization form in any way that violates HIPAA, they do so at their own peril.

5.

Upon good information and belief, the defendants' purpose is to provide benefits, which includes health care services to patients including at their facility in Fulton County. Therefore, defendants are subject to the jurisdiction and venue of this Court.

6.

Upon good information and belief, at the time of the events outlined in this Complaint, Kindred Healthcare Operating, Inc., Kindred Healthcare, Inc., Lafayette Health Care Center, Inc., Sally Goza, M.D., and any and all nurses, technicians, and other personnel at Kindred-Lafayette (collectively "defendants" or "Kindred" or "Kindred-Lafayette") who participated in evaluating, examining, and treating Mr. Coker between approximately October 16, 2012 and October 20, 2012, undertook a medical provider/patient relationship with Mr. Coker.

7.

Upon good information and belief, at all times material hereto, Kindred, Sally Goza, M.D., and any and all nurses, technicians, and other personnel at Kindred-Lafayette who participated in evaluating, examining, and treating Mr. Coker, between approximately October 16, 2012 and October 20, 2012, were actual or apparent

employees and/or agents of the remaining defendants and were acting in the course and scope of their employment, and thus all defendants are jointly and severally liable for their negligent acts or omissions and any injuries and damages arising therefrom either directly or derivatively caused by its employees and agents.

8.

All of the defendants shall, at times, be collectively referred to as “defendants” or “Kindred”.

9.

Lafayette Health Care Center, Inc. is a defendant in this case, is a Georgia corporation, and may be served with summons and a copy of this Complaint on its Registered Agent, C.T. Corporation System, 1201 Peachtree Street, NE, Atlanta, Georgia 30361, in Fulton County, Georgia. Lafayette Health Care Center, Inc. apparently utilizes a trade name known as “Kindred Transitional Care and Rehabilitation – Lafayette” and therefore, for purposes of this Complaint, Lafayette Health Care Center, Inc. will, on occasion, be referred to as “Kindred-Lafayette” or collectively with the other defendants as “Kindred.”

10.

Kindred Healthcare Operating, Inc. is a defendant in this case, does business in and operates a facility in Fulton County, and may be served with summons and a copy of this Complaint on its Registered Agent, The Corporation Trust Company,

Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware in New Castle County, Delaware and is additionally the alter-ego of the remaining corporate defendants. Defendant owns and operates a facility in Fulton County and for this reason, inter alia, venue is proper in this county.

11.

Kindred Healthcare, Inc. is a defendant in this case, does business in and operates a facility in Fulton County, and may be served with summons and a copy of this Complaint on its Registered Agent, The Corporation Trust Company, Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware in New Castle County, Delaware and is additionally the alter-ego of the remaining corporate defendants. Defendant owns and operates a facility in Fulton County and for this reason, inter alia, venue is proper in this county.

12.

Sally Goza, M.D. (“Dr. Goza”), is a defendant in this case and may be served with summons and a copy of this Complaint at her place of employment, Kindred Transitional Care and Rehabilitation – Lafayette, 110 Brandywine Boulevard, Fayetteville, Georgia 30214, in Fayette County, Georgia.

13.

Served contemporaneously herewith are Plaintiffs' First Continuing Interrogatories to Defendants and Plaintiffs' First Continuing Request for Production of Documents to Defendants.

14.

Filed contemporaneously herewith is Plaintiff's Request for a Trial by Jury of twelve (12) persons.

FACTUAL BACKGROUND

15.

Mr. Coker was treated by Dr. Goza and evaluated and examined by various other physician assistants and nurse practitioners at various times.

16.

Attached and incorporated by reference as Attachment "8" and Attachment "9" are the Affidavits of Perry J. Starer, MD and Georgette Bieber, RCN, who are qualified as expert witnesses on the issues raised in this Complaint. Said Affidavits specify at least one negligent act or omission on the part of each of the defendants and the factual basis that underlies the negligent acts or omissions that resulted in injuries, suffering and death of Robert L. Coker, deceased ("Mr. Coker" or "Decedent") and to the plaintiffs. The medical records referenced in their Affidavits and made a part of their opinions are found attached hereto as Attachments "1", "2", "3" and "4" (and successive parts).

17.

The purpose of Mr. Coker's admission to Kindred-Lafayette was to physically rehabilitate Mr. Coker and assist him in full use of his hip and leg post-surgery. The simple purpose of his admission to Kindred-Lafayette was to transition to walking again.

18.

As part of the admission process to Kindred-Lafayette, Robert A. "Andy" Coker (Decedent's son) transported Mr. Coker to Kindred-Lafayette and its personnel completed detailed questionnaires regarding Mr. Coker's physical condition.

19.

Andy disclosed to Kindred-Lafayette that due to the required, daily removal of a dental appliance from Mr. Coker that Mr. Coker should receive nothing but soft or pureed foods. Kindred's records reflected this request as shown in Attachment "1".

20.

Andy disclosed to Kindred-Lafayette personnel that Mr. Coker had dental appliances in both the upper and lower part of his mouth. This was reflected in records prepared by Kindred-Lafayette on October 16, 2012. See Attachment "1".

21.

Moreover, Andy commented to the staff at Kindred-Lafayette that Mr. Coker's upper dental piece recently appeared to be loose because Mr. Coker was making a "clicking" sound with his tongue against the roof of his mouth. The Kindred-

Lafayette personnel took no steps to alleviate this problem. In fact, the Kindred-Lafayette personnel that spoke with Andy, misdiagnosed the cause of the ill-fitting denture as a temporary weight loss caused by the surgery.

22.

During the following morning on October the 17th, Andy noticed a significant deterioration in Mr. Coker's condition. Mr. Coker was simply unable to communicate in any form or fashion although he had been fully able to communicate the day before. In addition, he made numerous disturbing noises (such as gurgling, etc.) and generally exhibited discomfort.

23.

Andy voiced his concerns to various staff members of Kindred-Lafayette as well as to the physician assigned by Kindred-Lafayette (Dr. Goza) starting Tuesday morning, October 17, 2012.

24.

Neither the employees nor Dr. Goza took any effective, meaningful action to investigate the troubled condition of Mr. Coker voiced to them by his son, Andy.

25.

On October 17, 2012, personnel at Kindred-Lafayette concluded that Mr. Coker needed to have fluids suctioned from the rear of his mouth and caused to suction the fluid using a Yankaeur suction catheter to complete the process. The particular

Yankaeur suction catheter used by the defendants had a rigid immovable suction end which does not ply or bend when it meets an obstruction. Upon information and belief, plaintiffs believe that the Yankaeur suction catheter used by the defendants caused the dental bridge of Mr. Coker to be further shoved down his throat below his uvula. (See Affidavit of Georgette Bieber, Attachment “9” at ¶ 16).

26.

The dental bridge shoved down Mr. Coker’s throat was approximately 6cm x 3cm. True and correct photographs of this dental bridge, which was shoved down Mr. Coker’s throat by defendants, are attached hereto as Attachment “10”.

27.

Throughout Wednesday, October 17, Thursday, October 18 and Friday, October 19, Andy frequently visited his father at Kindred-Lafayette and noticed his condition was worsening. Mr. Coker would slip in and out of sleep, was mumbling and expressing significant discomfort and pain including the continuing gurgling noise from the back of his throat. He remained unable, in any fashion, to communicate with Andy.

28.

The personnel and physicians at Kindred-Lafayette including Dr. Sally Goza, indicated that they were running various tests but that they were unable to diagnose Mr. Coker’s condition. Andy frequently and repeatedly complained and

unsuccessfully requested that Mr. Coker be transported to the local hospital emergency department, less than five (5) miles away. Although it is believed that Kindred-Lafayette possessed a portable x-ray machine on site, it is not reflected in Kindred's records (nor is it believed by plaintiffs) that Kindred ever used the equipment to attempt to evaluate Mr. Coker's condition.

29.

On Friday night, October 19th, Andy insisted that Kindred-Lafayette transfer Mr. Coker to the Piedmont Fayette Hospital Emergency Department because the Piedmont Fayette ER had more sophisticated equipment and staff designed to fully diagnose the problems Mr. Coker was experiencing. Despite Andy's numerous requests for a transfer to the Piedmont Fayette Emergency Department, the employees at Kindred-Lafayette generally disregarded this request and trivialized Andy's concerns.

30.

Ultimately, Kindred-Lafayette staff relented and informed Andy late Friday night that an ambulance would be provided for the transport of Mr. Coker to the emergency room. Approximately 45 minutes later, a private service ambulance arrived.

31.

After Mr. Coker was settled into the ambulance, Andy set out in his own vehicle to the emergency room and was waiting at the front door before the ambulance even pulled into the parking lot.

32.

The emergency room staff performed various examinations of Mr. Coker including X-rays. Shortly after Mr. Coker's arrival in the ER, the ER medical staff concluded that Mr. Coker had a dental appliance deep in his throat.

33.

The medical staff at the Piedmont Fayette Emergency Room declined to attempt removal and concluded that a specialist would be needed in order to extract the dental appliance since they feared that the dental appliance was inserted and had attached to the esophageal wall of Mr. Coker's inner throat. (See records at Attachment "2").

34.

At first, the Piedmont Fayette medical team recommended that a gastroenterologist would be the proper surgeon to remove the dental piece. This proved insufficient.

35.

At that point, the Coker family agreed that Mr. Coker be transported to Piedmont Atlanta Hospital for treatment and removal of the dental piece since the necessary medical specialists were not available at Piedmont Fayette Hospital.

36.

The following morning, Saturday, October 20, 2012 (after Mr. Coker's transport to Atlanta), a medical team from Piedmont Atlanta examined Mr. Coker. A gastroenterologist concluded that yet a different specialist was required for the extraction of the dental appliance due to the severity of the injuries. The concern was that the dental appliance was so deep in the throat that it might be necessary to enter the throat cavity through an incision to the outer wall of Mr. Coker's throat.

37.

A tracheal surgeon was summoned to the hospital. The Coker family was required to sign numerous waivers and assumptions of risk including the recognition that Mr. Coker could die during this procedure due (potentially in part) to bleeding to death from the removal of the dental appliance. At approximately 10:00 a.m. on October 20th, 2012, the dental appliance was extracted from Mr. Coker's throat and given to Andy.

38.

Andy has kept the dental appliance in his possession, custody and control since that day. True and correct photographs of this dental appliance appear attached hereto as Attachment "10".

39.

On October 16, 2012 Mr. Coker was placed in the defendants' facility located at 110 Brandywine Road, Fayetteville, Georgia as an inpatient for his proper care and maintenance which required defendants' due regard to his need for rehabilitation.

40.

On or about October 16, 2012 Mr. Coker was admitted to Lafayette Health Care which required defendants' due regard and recognition of his complete need for supervision and care during his rehabilitation.

41.

Because the defendants negligently failed to observe Mr. Coker and to listen and heed the complaints of pain given by Mr. Coker and his son, the condition of Mr. Coker (1) continued to worsen and deteriorate, (2) made it impossible for his broken hip to be properly treated, (3) caused the continued loss of oxygen to Mr. Coker, (4) caused incredible suffering by Mr. Coker, and (5) caused the death of Mr. Coker.

42.

The negligence of the defendants contributed to and caused the death of Mr. Coker on or about March 23, 2013.

43.

The negligence of the defendants herein contributed to and caused Mr. Coker to suffer intense physical pain and mental suffering until his death on March 23, 2013.

44.

The death of Mr. Coker was caused by the negligence of the acts and omissions of the agents, employees and apparent agents of the defendants as set out herein.

45.

The defendants, in operating their nursing facility located at 110 Brandywine Road, Fayetteville, Georgia breached and disregarded their duties, failed to exercise such care and skill in that the defendants failed to properly administer proper nursing care to Mr. Coker and that in operating their nursing facility violated those standards of care applicable to nursing facilities similar to that of the facility located at 110 Brandywine Road, Fayetteville, Georgia in that they:

- a. Failed to provide competent professional personnel capable of properly examining patients and in properly recognizing the need to call in appropriate medical doctors to examine and treat patients;
- b. Failed to call in a doctor or refer him to a doctor to examine Mr. Coker's condition;
- c. Did not follow the care plan provided for Mr. Coker;
- d. Failed to effectively administer to Mr. Coker's care to maintain his highest well-being and did not monitor his condition and coordinate his care with other healthcare providers;
- e. Failed to maintain complete and accurate clinical records;

- f. Failed to monitor Mr. Coker's daily intake;
- g. Failed to perform a formal and accurate assessment of Mr. Coker's condition;
- h. Ignored the care plan prepared for Mr. Coker;
- i. Negligently permitted either incompetent or inadequately trained and/or supervised personnel to work at the defendants' nursing home which resulted in the failure to properly examine and treat Mr. Coker;
- j. Allowing its nursing home personnel and medical/nursing personnel to examine and treat Mr. Coker when, as evidenced by the inadequate care and treatment of Mr. Coker, they failed to exhibit the knowledge and skill and experience of practitioners with similar training and experience practicing in Fayetteville, Fayette County, Georgia community or other similar communities in 2012;
- k. Failed to insure through its policies and procedures that Mr. Coker received the requisite degree and standard of nursing home care and treatment regularly experienced at similar nursing homes;
- l. Breached an implied representation of its duty to Mr. Coker that the defendants' nursing homes and its staff was competent and would provide proper care and treatment for him and monitor and oversee and supervise the nursing and related personnel;

m. Failed to provide qualified trained, experienced and capable nursing home staff to properly administer and monitor the examination and treatment of patients;

n. The defendants' nursing home staff were negligent in that the care and treatment given by the defendants' nursing home through its agents and employees both named herein and unnamed, was not in accordance with the standards of practice exercised among physicians, registered nurses, licensed practicing nurses and certified nursing assistants and nursing home staffs with similar training and experience as those of the individuals who were assigned to the care for Mr. Coker who practice in communities similar to Fayetteville, Fayette County, Georgia. This failure to provide services with the standard of care as detailed herein constitutes negligence;

o. Failed to exercise reasonable care and diligence in the application of its knowledge and the knowledge of its personnel to the care and treatment given to Mr. Coker and it did not use its best judgment in the treatment and care of Mr. Coker during that period of time in which Mr. Coker was under the care and treatment of the defendants' nursing home; and it did not exercise that degree of care which was in accordance with the standard of practice among nursing home and nursing home staff similarly trained, experienced and situated in similar communities at the time of the treatment of Mr. Coker;

p. That the negligence of the individual defendants named herein and others unnamed who were assigned by the defendants' nursing home to render care to Mr. Coker is imputed to all of the defendants;

q. Failed to exercise due and reasonable care for Mr. Coker;

r. The defendants did not x-ray Mr. Coker and did not have Mr. Coker x-rayed when Mr. Coker evidenced pain;

s. The defendants did not properly monitor, watch, and observe Mr. Coker and did not observe that he had demonstrated signs and symptoms of a swallowed dental bridge;

t. The defendants ignored the complaints of pain made by Mr. Coker and his family and failed to act upon those complaints of pain by referring him to an outside doctor, ordering x-rays, or otherwise examining him or having him examined at another facility (i.e., the local emergency room) which had superior equipment and facilities;

u. Failed to exercise due and reasonable care in the selection and/or retention of its employees who were involved in the care and treatment of Mr. Coker as set out above who were not sufficiently trained and skilled to examine and treat patients and were incompetent and/or inexperienced;

v. That the agents and employees of the defendants' nursing home which were assigned and rendered care and treatment to Mr. Coker, failed to exercise

reasonable care and diligence in the treatment and care of Mr. Coker and that the defendants' nursing home is responsible under the doctrine of Respondeat Superior;

w. That the defendant nursing home failed to make reasonable effort to monitor and oversee Mr. Coker's condition despite the fact that he continued to show evidence of increasing pain and suffering;

x. The defendants' nursing home failed to exercise reasonable care and diligence in its examination and treatment of Mr. Coker from approximately October 16, 2012 through approximately October 19, 2012;

y. The agents and employees of the defendants' nursing home, including the registered nurses and other nursing personnel failed to exhibit the knowledge and skill which was possessed by other registered nurses and other nursing personnel with similar training and experience practicing in the Fayetteville, Fayette County, Georgia communities or similar communities at all times mentioned;

z. The agents and employees of the defendants' nursing home, including the registered nurses and other nursing personnel failed to exercise care and diligence in the application of their knowledge as registered nurses and other nursing personnel to the care and treatment of Mr. Coker and did not use their best judgment in the treatment and care of Mr. Coker during the period and time that Mr. Coker was a patient at the defendants' nursing home from approximately October 16, 2012 through approximately October 19, 2012;

aa. The nursing personnel who were involved in the examination or treatment of Mr. Coker were acting within the course and scope of their employment for the defendants' nursing home and were agents and employees of the remaining defendants in the administration of nursing home services to Mr. Coker; and

bb. The negligence of the individual nurses and other nursing personnel as set out above is imputed to all of the defendants.

COUNT I

SIMPLE NEGLIGENCE

46.

Plaintiffs adopt and reallege paragraphs 1 through 45 as though fully realleged and form paragraphs 1 through 45 of this Count.

47.

At all times mentioned herein a health care provider-patient relationship existed between Mr. Coker and the physicians, staff and nurses on duty at the defendants' nursing facility.

48.

At all times mentioned herein the defendants' facility located at 110 Brandywine Boulevard, Fayetteville, Georgia held itself out to the public and to the plaintiffs as providing nursing home services and skilled care nursing services and nursing facilities and rehabilitation services and including adult care home beds in

combination facilities. Mr. Coker and his family looked to the defendants' nursing facility and to the individual doctors, nurses and nursing personnel to provide appropriate nursing care for Mr. Coker. The plaintiffs placed Mr. Coker in that facility in the reasonable belief that those services were being rendered in an appropriate manner by the nursing home, nursing facility or its employees, agents or apparent agents.

49.

The negligence of the individual physicians, registered nurses, licensed practicing nurses and other personnel as set out herein is imputed to all of the defendants.

50.

At all times mentioned herein it was the duty of the defendants in operating the nursing facility located at 110 Brandywine Road, Fayetteville, Georgia to exercise that degree of care in accordance with the standard of practice among members of the healthcare profession with similar training and experience situated in the same or similar community at the time of the acts alleged herein.

51.

The defendants, acting through its agents and employees and its apparent agents owed Mr. Coker a duty to exercise reasonable care and diligence, to exercise their best medical and nursing judgment and to comply with the standards of practice among

members of the same health care profession with similar training, experience and situated in the same or similar communities in 2012.

52.

As a direct and proximate result of the agents and apparent agents of the defendants and as a direct result of the negligence of the defendants as alleged herein the Mr. Coker died on March 23, 2013. Further, as a result of this negligence the plaintiffs, Betty Ann Coker, Robert A. Coker and Sherri A. Hutson, have been deprived of their husband's and father's services, care, society, companionship, comfort and guidance. Further, other members of the family of Mr. Coker, as a result of the negligence of these defendants have been deprived of the services, care, society, companionship, comfort and guidance of their husband, father, grandfather and great-grandfather.

53.

Plaintiffs are also entitled to recover reasonable attorney's fees and expenses of litigation with respect to the claims pursuant to O.C.G.A. § 13-6-11 because defendants acted in bad faith and have been stubbornly litigious.

COUNT II

MEDICAL NEGLIGENCE

54.

Plaintiffs adopt and reallege paragraphs 1 through 53 as though fully realleged and form paragraphs 1 through 53 of this Count.

55.

Sally Goza, M.D., and any and all nurses, technicians, other personnel at Lafayette Health Care Center, Inc., and Kindred-Lafayette were required to exercise that degree of care and skill ordinarily employed by health care providers generally when dealing with like conditions and similar circumstances as Mr. Coker experienced between approximately October 16, 2012 and approximately October 19, 2012.

56.

The defendants in general, and Dr. Sally Goza in particular, (as shown in the Affidavit of Perry J. Starer, M.D., herein as Attachment “8”):

- a. Failed to fully assess Mr. Coker’s condition and needs;
- b. Failed to protect Mr. Coker from the obvious injury due to the failure to remove his dental bridge before retirement;
- c. Violated the standards of care by allowing the advancement of his dental bridge further down his throat;
- d. Failed to complete the investigation of the problems as presented with symptoms after the swallowing of the dental bridge;
- e. Failed to promptly transport Mr. Coker to the Piedmont Fayette Emergency Room where superior review resources and equipment were available.

57.

Sally Goza, M.D., and any and all nurses, technicians, other personnel at Lafayette Health Care Center, Inc., and Kindred-Lafayette performing care on Mr. Coker between approximately October 16, 2012 and October 19, 2012, deviated from the standard of care outlined in the immediately preceding paragraph in that they failed to exercise the degree of care and skill required by health care providers generally, inter alia, by failing to promptly consider the medical records available and on hand at Lafayette Healthcare Center.

58.

As a direct and proximate result of the failure to exercise appropriate care on the part of Sally Goza, M.D., nurses, technicians, other individuals at Lafayette Health Care Center, Inc., and Kindred-Lafayette performing care on Mr. Coker between approximately October 16, 2012 and approximately October 19, 2012, Mr. Coker suffered extreme damage, pain and suffering.

59.

Attached and incorporated by reference as Attachment “8” is the Affidavit of Perry J. Starer, M.D., who is qualified as an expert witness on the issues raised in this Complaint. Said Affidavit specifies at least one negligent act or omission on the part of the defendants and of Dr. Sally Goza and the remaining defendants and the factual

basis that underlies the negligent acts or omissions that resulted in injuries to Mr. Coker as is also more fully realleged in this Complaint.

60.

Attached and incorporated by reference as Attachment “9” is the Affidavit of Georgette M. Bieber, RN C, LNCC, who is qualified as an expert witness on the issues raised in this Complaint. Said Affidavit specifies at least one negligent act or omission on the part of the defendants and of the nursing staff and the factual basis that underlies the negligent acts or omissions that resulted in injuries to Mr. Coker as is also more fully realleged in this Complaint.

COUNT III

GROSS NEGLIGENCE

61.

Plaintiffs adopt and reallege paragraphs 1 through 60 as though fully realleged and form paragraphs 1 through 60 of this Count.

62.

The parties agreed that the defendants would provide medical, nursing, and rehabilitation services to Mr. Coker.

63.

The defendants freely and consciously assumed the aforementioned duties of providing competent medical care to Mr. Coker.

64.

The defendants had an implied duty to perform their duties in a manner consistent with the standard of care in the community.

65.

The defendants provided, supervised and controlled the work.

66.

The defendants failed to render care in a good and careful manner.

67.

The defendants exhibited a complete lack of care and reckless indifference to the rights of the plaintiffs and/or Mr. Coker.

68.

Defendants owed a duty of reasonable care and diligence to plaintiffs and Mr. Coker.

69.

Defendants failed to exercise reasonable or slight care and diligence in failing to properly monitor the care of Mr. Coker, the same constituting gross negligence and negligence per se by the defendants.

70.

As a result of the defendants' negligence, the plaintiffs and Mr. Coker have been damaged.

71.

The defendants have exhibited reckless and willful indifference to the rights of the plaintiffs and Mr. Coker.

72.

Plaintiffs and Mr. Coker have been damaged by the defendants' gross negligence.

73.

Defendants' failure to properly perform was the proximate cause of plaintiffs' and of Mr. Coker's damage and death.

74.

The defendants are liable in gross negligence and for the assessment of actual and punitive damages under O.C.G.A. §51-12-5.1 since they have demonstrated willful misconduct and that entire want of care which raises the presumption of conscious indifference to consequences.

COUNT IV

NEGLIGENT HIRING, TRAINING, SUPERVISION AND

RETENTION OF EMPLOYEES

75.

Plaintiffs adopt and reallege paragraphs 1 through 74 as though fully realleged and form paragraphs 1 through 74 of this Count.

76.

Upon information and belief, Kindred-Lafayette has had previous employment/employee issues related to the sound provision of medical care.

77.

Based upon this knowledge, at the time of Mr. Coker's admission to Kindred-Lafayette and including October 16th through October 19th, 2012, Defendants were negligent in hiring, training, supervising and retaining the employees who caused the injuries and, ultimately the death of Mr. Coker.

COUNT V

LOSS OF CONSORTIUM

78.

Plaintiffs adopt and reallege paragraphs 1 through 77 as though fully realleged and form paragraphs 1 through 77 of this Count.

79.

As a direct and proximate result of Defendant's negligence, causing the injuries to Robert L. Coker, Plaintiffs also bring this action for the loss of the society, companionship and consortium between Robert L. Coker and Betty J. Coker brought about by the personal injuries which Mr. Coker sustained as a result of the negligence of the Defendants.

COUNT VI

ESTABLISHMENT OF LIABILITY THROUGH IMPOSITION

OF ALTER EGO THEORY

80.

Plaintiffs adopt and reallege paragraphs 1 through 79 as though fully realleged and form paragraphs 1 through 79 of this Count.

81.

Defendants Kindred Healthcare Operating, Inc., Kindred Healthcare, Inc. and Lafayette Health Care Center, Inc. have interlocking memberships and directorships.

82.

Each of the three (3) Kindred defendants has attempted to extend benefits and legal rights to each other by and through the Lafayette Healthcare, et al, including efforts to contract with representatives of Robert L. Coker. As a consequence of these shared benefits and shared opportunities, the Kindred defendants have assumed joint and several liability for all acts complained of in the instant Complaint.

83.

The only way in which justice can be served and plaintiffs' and Mr. Coker's rights to be preserved is for Kindred and Lafayette to be held responsible, jointly and severally.

84.

Kindred Healthcare Operating, Inc. and Kindred Healthcare, Inc. in fact controlled the method, manner and means by which the attempted and grossly negligent medical service was provided to Mr. Coker between October 16, 2012 and October 19, 2012.

COUNT VII

DAMAGES DUE TO WRONGFUL DEATH

85.

Plaintiffs adopt and reallege paragraphs 1 through 84 as though fully realleged and form paragraphs 1 through 84 of this Count.

86.

The death of Mr. Coker resulted from the acts of negligence and gross negligence of the Defendants.

87.

Plaintiffs are entitled to recover the full value of Mr. Coker's life.

88.

Plaintiffs are entitled to recover all damages accruing as a result of the death of Mr. Coker, including medical expenses, funeral home expenses and burial expenses.

WHEREFORE, Plaintiffs pray:

- (a) that this Court grant a trial by jury as to all issues so triable;

(b) for general damages as shall be determined by the enlightened conscience of a fair and impartial jury;

(c) for actual damages as shall be proven at trial;

(d) for punitive damages as shall be determined by the enlightened conscience of a fair and impartial jury;

(e) for reimbursement of the expenses of death including burial expenses;

(f) for attorneys fees and costs of this action;

(g) for such other and further relief as is just and proper.

This 26 day of March, 2014.

/s/ JOHN W. MROSEK, ESQ. 03/26/14

JOHN W. MROSEK, ESQ.
Attorney for Plaintiffs
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**KINDRED
LAFAYETTE
RECORDS**

SKILLED NURSING FACILITY INITIAL ASSESSMENT

Resident Name: *Robert Coker*

Date: *10-17-12*¹

Room# *501*

Primary Care Physician

Specialists:

Family

Present Absent

Chief Complaint:

hip ft

History of Present Illness

*Mr. Coker is an 85 yo o→
slp surgery for @ hip fracture
10-9-12 by Dr. Goodman*

Resident Name: Robert Coker

Date: 10-17-12²

Room# 501A

Past Medical History

Parkinson's disease / dementia

heart disease

a-fib

cardiomyopathy

EF 35-40%

aortic stenosis

BPIT

htr

peptic ulcer disease

h/o TIA

hypothyroidism

slp knee repair

Resident Name: Robert Coker

Date: 10-17-12 3

Room# 501A

Medications:

Lasix 10/100 QID

arcept 10 x qhs

finasteride 5mg daily

folic acid 1mg daily

lasix 20mg daily

synthroid 50mg daily

namenda 5x BID

Protonix 40x daily

flomax 0.4x qm

syntane OU QID

lopressor 25mg BID

coumadin 7.5 x daily

Medication Allergies

Pen, apio, bactrim,
sulfa, chondamycin

Resident Name: *Robert Coker*

Date: *10-17-12* 4

Room# *501A*

Social History: Information provided by : ☒ Patient
☐ Other

With whom do you live?

Do you smoke?

Do you drink alcohol?

Family History Information provided by : ☐ Patient
☐ Other

Pt cannot provide social history, family history, or review of systems

Review of systems: Information provided by : ☐ Patient
☐ Other

Chest pain?

Shortness of Breath?

Last Bowel Movement?

Weight Loss/Weight Gain?

Fever?

Are you in pain?

Do you drive?

Resident Name: *Robert Coker*

Date: *10-17-12*

5

Room# *501A*

Were you able to walk 2 weeks prior to hospital admission?

How did you manage your ADLs 2 weeks prior to hospital admission?

Bathing Independent Required Assistance

Dressing Independent Required Assistance

Toileting Independent Required Assistance

Do you have any incontinence of bladder?

Do you have trouble voiding?

Do you have an enlarged prostate?

Do you have a pacemaker?

Do you have heartburn, indigestion or reflux?

Do you have a history of ulcers?

Have you noticed problems with short term memory?

Do you have anxiety?

Do you have depression?

Do you have seasonal allergies?

Do you have Glaucoma?

Do you have Hypothyroidism?

Do you have seizures?

Resident Name: *Robert Coker*Date: *10-17-12* 6Room# *501*

Physical Examination:

BP

146/76

T

97.8

P

89 20

R

O2Sat

91% Room air

General

*Alert & somnolent but
does wake to
voice*

Heent

Face Symmetric

*EQMI - keeps eyes closed
Oral mucosa is moist Pupils equal &
reactive*

Lungs

Clear upper airway no rales

Cardiovascular

*RR**No murmurs**No JVD*

Abdomen

soft and non-tender

Extremities

0 LE edema

Neuro/Musculoskeletal

*Able to raise arms over head off bed but
not overhead**Hand grips equal**Plantar and dorsiflexion intact bilaterally*

Skin

Palpation reveals skin turgor is good

Foley catheter present

Yes ☒ No

PICC line/Midline present

Yes ☒ No*Pt cannot answer any questions
② hip incision i staples
③ entheone ④ drainage*

Resident Name: *Robert Coker*

Date: *10-17-12* ⁷

Room# *501*

Mental Status Examination:

What is your name?

Where are you now?

What year is it?

What month is it?

What day is it?

Why were you in the hospital?

*Patient not able
to participate*

SLUMS Examination

Assessment:

hip fx

Plan:

dementia

PT/OT

ST eval

CXR

CMP CBC

add protocol

Advance directives discussed with patient, who shows good understanding and requests no CPR in the event of cardiac or respiratory arrest.

Advance directives discussed with patient, who shows good understanding and requests CPR in the event of cardiac or respiratory arrest.

Advance directives discussed with patient, who shows good understanding and is undecided.

Advance directives not discussed.

[Signature]
Wendy Goza, M.D.



RECORD OF ADMISSION TO

Kindred Transitional Care And Rehabilitation-Lafayette 1228
 Facility Name Facility No
 110 Brandywine Boulevard
 Street Address
 Fayetteville, GA. 30214
 City, State, Zip Code

deans

Name of person preparing this form

10/23/2012

Date

IDENTIFICATION SUMMARY

Resident Name (Last) (First) (Middle) Nickname	Patient Number	Date Admitted	Room Number
Coker Robert	123965	10/16/2012	0401
Usual Residence - Street (if rural give location)	Primary Language	Previous Admission Date	Social Security Number
1209 Bay Club Circle			253-34-8532
City/Town (if precinct no. if applicable)	State	Zip Code	Sex
Tampa	GA	33607	Male
County	Home Phone	Citizenship	Birthplace
	(678) 300-2140	USA	06/16/1927
PDP Organization Name	PDP Plan	Religion	Date of Birth
	Pending PDP Selection		85
Medicare A Number	Medicare B Number	Medicaid Number	Age
253348532A	253348532A		
Name of Primary Insurance Company	Address	Insurance Policy Number/Group Number	Usual occupation
Name of Secondary Insurance Company	Address	Insurance Policy Number/Group Number	
Attending Physician	Address	(W) Phone	FAX
Wendy Goza	110 Brandywine Blvd., Fayetteville, GA. 30214	(770) 461-2928	
Alternate Physician	Address	(W) Phone	FAX
Ferroll Sams, III	101 Yorktown Drive, Fayetteville, GA. 30214	(770) 460-3000	
Dentist	Address	(W) Phone	FAX
Choice Family			
Financial Agent, relationship	Address	(H) Phone	(W) Phone
Andy Coker, Son	Vb Vb GA 11225	(678) 300-2140	
Person to notify in Emergency, relationship	Address	(H) Phone	(W) Phone
Sherry Hudson, Daughter	1209 Bay Club Circle, Tampa, FL. 33607	(404) 379-4296	
Person to notify in Emergency, relationship	Address	(H) Phone	(W) Phone
Andy Coker, Son	Vb, Vb, GA. 11225	(678) 300-2140	
Mortuary to notify in case of death	Address		Phone
Contact Family	Address		Phone
Admitted From (if Institution, give Name, Address and Phone)	Address		
Piedmont Fayette Hospital	1255 Highway 54 West, Fayetteville, GA. 30214		(770) 719-7000
How Transferred To Facility	Referred By:	If admitted from institution, give dates of stay	
	Dr Adamnasser	10/07/2012 - 10/16/2012	
NOTES/COMMENTS/ALLERGIES			
Andy Coker (Son)			

ADMISSION SUMMARY

Primary Admitting Diagnosis: This patient has been informed of his physical and mental condition and plan of treatment:
☐ Yes ☐ No If NO, explain: _____
 Secondary Admitting Diagnosis: _____
 Rehabilitation Potential: _____
 Prognosis: _____

Transcribing Nurse's Signature _____ Date _____ *Physician's Signature _____ Date _____
 * If this section is not signed by the Physician, this summary information has been transcribed from document(s) contained in this patient's clinical record which appropriately bear the physician's signature.

DISCHARGE SUMMARY*

Discharge Date	Discharge Time		
Accompanied By (Name)	Relationship:	Address	City State Zip
Place Discharge to	Address	City State Zip	Phone
Discharge Diagnosis:	Condition on Discharge Recovered Improved Unimproved Declined Treatment		
Course of Treatment:	or Other (Explain):		
Prognosis:			
Transcribing Nurse's Signature	Date	*Physician's Signature	Date
* If this section is not signed by the Physician, this summary information has been transcribed from document(s) contained in this patient's clinical record which appropriately bear the physician's signature.			

Resident's Name Case Number
 Robert Coker 123965

ADMISSION/DISCHARGE SUMMARY

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Name of Facility			Address		
Kindred			110 Brandywine Blvd		
Family Name		First Name	Admission Number	Room No.	Attending Physician
Coker Robert				501A	DR. GORE
Date Ordered	Time Ordered	Date Discont.	Orders		
10-19-12	5:05 pm		bld crumach		
Signature of Nurse Receiving Order			Signature of Physician		
S. K. K. S. O. E.			[Signature]		
<input type="checkbox"/> Resident Notified			<input type="checkbox"/> Family Notified		
On MD Order Sheet			Med/Tx Sheet		
Pharmacy			Nurses Notes		
Date & Time			Communicated / Read Back		
Signed			Signed		

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Name of Facility			Address		
LNRC			110 Brandywine Blvd		
Family Name		First Name	Admission Number	Room No.	Attending Physician
Coker Robert				501A	DR. GORE
Date Ordered	Time Ordered	Date Discont.	Orders		
10/19/12			Send to PTH ER for Eval		
Signature of Nurse Receiving Order			Signature of Physician		
[Signature]			[Signature]		
<input type="checkbox"/> Resident Notified			<input type="checkbox"/> Family Notified		
On MD Order Sheet			Med/Tx Sheet		
Pharmacy			Nurses Notes		
Date & Time			Communicated / Read Back		
Signed			Signed		

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Name of Facility			Address		
Family Name		First Name	Admission Number	Room No.	Attending Physician
Date Ordered	Time Ordered	Date Discont.	Orders		
Signature of Nurse Receiving Order			Signature of Physician		
<input type="checkbox"/> Resident Notified			<input type="checkbox"/> Family Notified		
On MD Order Sheet			Med/Tx Sheet		
Pharmacy			Nurses Notes		
Date & Time			Communicated / Read Back		
Signed			Signed		

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ea/c

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility	LNUC		Address		110 Brandwine Blvd	
Family Name	Robert	First Name	Admission Number	Room No.	G039	
Date Ordered	10/18/12	Time Ordered	Orders			
Date Discont.			D/C mechanical s/t consistency to pure consistency. Cont all previous dietary restrictions.			
Signature of Nurse Receiving Order			Signature of Physician		Date 2-1-12	
Initials			Initials		Initials	
<input checked="" type="checkbox"/> On MD Order Sheet	EA	<input checked="" type="checkbox"/> Med/Tx Sheet	EA	<input checked="" type="checkbox"/> Date & Time	EA	<input checked="" type="checkbox"/> Communicated / Read Back
<input checked="" type="checkbox"/> Pharmacy	EA	<input checked="" type="checkbox"/> Nurses Notes	EA	<input checked="" type="checkbox"/> Pt. Care Plan	EA	<input checked="" type="checkbox"/> Signed

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility	Lafayette (United)		Address		110 Brandwine Blvd Fayetteville, GA	
Family Name	Robert	First Name	Admission Number	Room No.	G029	
Date Ordered	10/12/12	Time Ordered	Orders			
Date Discont.			D/C fentanyl and aztreonam IV. Start fentanyl 500mcg PO QID for 2 weeks. Start Aztreonam 1 gram IV Q8 hours for 2 weeks. Give Durab rebiol treatments QID.			
Signature of Nurse Receiving Order			Signature of Physician		Date 2-1-12	
Initials			Initials		Initials	
<input checked="" type="checkbox"/> On MD Order Sheet	EA	<input checked="" type="checkbox"/> Med/Tx Sheet	EA	<input checked="" type="checkbox"/> Date & Time	EA	<input checked="" type="checkbox"/> Communicated / Read Back
<input checked="" type="checkbox"/> Pharmacy		<input checked="" type="checkbox"/> Nurses Notes		<input checked="" type="checkbox"/> Pt. Care Plan		<input checked="" type="checkbox"/> Signed

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility	Lafayette (United)		Address		110 Brandwine Blvd Fayetteville, GA	
Family Name	Robert	First Name	Admission Number	Room No.	G029	
Date Ordered	10/19/12	Time Ordered	Orders			
Date Discont.	12/30		Resident to have G/C 34pm 02 via NC DX SOB v.o. on G039 / C. J. Smith MD RRT (RBV)			
Signature of Nurse Receiving Order			Signature of Physician		Date 2-1-12	
Initials			Initials		Initials	
<input checked="" type="checkbox"/> On MD Order Sheet		<input checked="" type="checkbox"/> Med/Tx Sheet		<input checked="" type="checkbox"/> Date & Time		<input checked="" type="checkbox"/> Communicated / Read Back
<input checked="" type="checkbox"/> Pharmacy		<input checked="" type="checkbox"/> Nurses Notes		<input checked="" type="checkbox"/> Pt. Care Plan		<input checked="" type="checkbox"/> Signed

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility			Address		
Family Name <i>Robert</i>		First Name	Admission Number	Room No.	Attending Physician
Date Ordered	Time Ordered	Date Discont.	Orders		
			<i>Lactovaccinus T PO BID</i>		
	<i>10-18-12</i>		<i>BMP, CBC i/d/r p/t, TSH, B-12 10-19-12</i>		
	<i>11:40 am</i>		<i>Wound for VA/GS dx fever 10/18/12</i>		
Signature of Nurse Receiving Order <i>Ea Cel, RN</i>			<input type="checkbox"/> Resident Notified <input type="checkbox"/> Family Notified		Signature of Physician <i>W/D 10/18/12</i>
<input checked="" type="checkbox"/> On MD Order Sheet <input checked="" type="checkbox"/> Pharmacy		Initials <i>Ea</i>	<input checked="" type="checkbox"/> Med/Tx Sheet <input checked="" type="checkbox"/> Nurses Notes		Initials <i>Ea</i>
			<input checked="" type="checkbox"/> Date & Time <input checked="" type="checkbox"/> Pt. Care Plan		Initials <i>Ea</i>
					<input checked="" type="checkbox"/> Communicated / Read Back <input checked="" type="checkbox"/> Signed

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility			Address		
Family Name <i>Robert</i>		First Name	Admission Number	Room No.	Attending Physician
Date Ordered	Time Ordered	Date Discont.	Orders		
			<i>hold ancept</i>		
	<i>10-18-12</i>		<i>hold norelco</i>		
	<i>11:40 am</i>		<i>hold nycodone</i>		
Signature of Nurse Receiving Order <i>Ea Cel, RN</i>			<input type="checkbox"/> Resident Notified <input type="checkbox"/> Family Notified		Signature of Physician <i>W/D 10/18/12</i>
<input checked="" type="checkbox"/> On MD Order Sheet <input checked="" type="checkbox"/> Pharmacy		Initials <i>Ea</i>	<input checked="" type="checkbox"/> Med/Tx Sheet <input checked="" type="checkbox"/> Nurses Notes		Initials <i>Ea</i>
			<input checked="" type="checkbox"/> Date & Time <input checked="" type="checkbox"/> Pt. Care Plan		Initials <i>Ea</i>
					<input checked="" type="checkbox"/> Communicated / Read Back <input checked="" type="checkbox"/> Signed

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility			Address		
Family Name <i>Robert</i>		First Name	Admission Number	Room No.	Attending Physician
Date Ordered	Time Ordered	Date Discont.	Orders		
	<i>10-18-12</i>		<i>Please call Dr. Hood - may we remove</i>		
	<i>4:05 pm</i>		<i>stitches & dressing from recent</i>		
			<i>surgical procedure</i>		
Signature of Nurse Receiving Order <i>Ea Cel, RN</i>			<input type="checkbox"/> Resident Notified <input type="checkbox"/> Family Notified		Signature of Physician <i>W/D 10/21/12</i>
<input checked="" type="checkbox"/> On MD Order Sheet <input checked="" type="checkbox"/> Pharmacy		Initials <i>Ea</i>	<input checked="" type="checkbox"/> Med/Tx Sheet <input checked="" type="checkbox"/> Nurses Notes		Initials <i>Ea</i>
			<input checked="" type="checkbox"/> Date & Time <input checked="" type="checkbox"/> Pt. Care Plan		Initials <i>Ea</i>
					<input checked="" type="checkbox"/> Communicated / Read Back <input checked="" type="checkbox"/> Signed

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility <i>Robert</i>			Address		
Family Name <i>Robert</i>		First Name	Admission Number	Room No.	Attending Physician
Date Ordered <i>10-18-12</i>	Time Ordered <i>11:40am</i>	Date Discont.	Orders		
<i>edace 100g PO BID</i>					
<i>minerals 17 grams in liquid PO q day</i>					
<i>do not give if pt having loose stools</i>					
<i>moisture barrier to sacrum + buttocks q shift</i>					
<i>skin prep to heels daily</i>					
Signature of Nurse Receiving Order <i>Easton LPN</i>			<input type="checkbox"/> Resident Notified <input type="checkbox"/> Family Notified		Signature of Physician <i>W/O</i> Date <i>10-18-12</i>
<input checked="" type="checkbox"/> On MD Order Sheet	Initials <i>ea</i>	<input checked="" type="checkbox"/> Med/Tx Sheet	Initials <i>ea</i>	<input checked="" type="checkbox"/> Date & Time	Initials <i>ea</i>
<input checked="" type="checkbox"/> Pharmacy	<i>ea</i>	<input checked="" type="checkbox"/> Nurses Notes	<i>ea</i>	<input checked="" type="checkbox"/> Pt. Care Plan	<i>ea</i>
			<input checked="" type="checkbox"/> Communicated / Read Back		
			<input checked="" type="checkbox"/> Signed		

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility <i>Robert</i>			Address		
Family Name <i>Robert</i>		First Name	Admission Number	Room No.	Attending Physician
Date Ordered <i>10-18-12</i>	Time Ordered <i>11:40am</i>	Date Discont.	Orders		
<i>flaccid heels when in bed</i>					
<i>call Dr. Goodman's office for depth removal</i>					
<i>dry dressing to hip incision & daily</i>					
Signature of Nurse Receiving Order <i>Easton LPN</i>			<input type="checkbox"/> Resident Notified <input type="checkbox"/> Family Notified		Signature of Physician <i>W/O</i> Date <i>10-18-12</i>
<input checked="" type="checkbox"/> On MD Order Sheet	Initials <i>ea</i>	<input checked="" type="checkbox"/> Med/Tx Sheet	Initials <i>ea</i>	<input checked="" type="checkbox"/> Date & Time	Initials <i>ea</i>
<input checked="" type="checkbox"/> Pharmacy	<i>ea</i>	<input checked="" type="checkbox"/> Nurses Notes	<i>ea</i>	<input checked="" type="checkbox"/> Pt. Care Plan	<i>ea</i>
			<input checked="" type="checkbox"/> Communicated / Read Back		
			<input checked="" type="checkbox"/> Signed		

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility <i>Robert</i>			Address		
Family Name <i>Robert</i>		First Name	Admission Number	Room No.	Attending Physician
Date Ordered <i>10-18-12</i>	Time Ordered <i>11:40am</i>	Date Discont.	Orders		
<i>dc levamisole 500g IV q day</i>					
<i>Begin of apixilon 17 grams IV q 8h</i>					
<i>x 2 weeks</i>					
Signature of Nurse Receiving Order <i>Easton LPN</i>			<input type="checkbox"/> Resident Notified <input type="checkbox"/> Family Notified		Signature of Physician <i>W/O</i> Date <i>10-18-12</i>
<input checked="" type="checkbox"/> On MD Order Sheet	Initials <i>ea</i>	<input checked="" type="checkbox"/> Med/Tx Sheet	Initials <i>ea</i>	<input checked="" type="checkbox"/> Date & Time	Initials <i>ea</i>
<input checked="" type="checkbox"/> Pharmacy	<i>ea</i>	<input checked="" type="checkbox"/> Nurses Notes	<i>ea</i>	<input checked="" type="checkbox"/> Pt. Care Plan	<i>ea</i>
			<input checked="" type="checkbox"/> Communicated / Read Back		
			<input checked="" type="checkbox"/> Signed		

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility			Address		
Family Name		First Name	Admission Number	Room No.	Attending Physician
Date Ordered	Time Ordered	Date Discontinued	Orders		
10-18-2011	11:15		PIC Levaquin IV Aztreonam 1g IV Q8h x 2 weeks Dx: Pneumonia V.O. Dr. Gora / Cynthia Taylor		
Signature of Nurse Receiving Order			<input type="checkbox"/> Resident Notified <input type="checkbox"/> Family Notified	Signature of Physician	
Initials			Initials	Initials	Date
On MD Order Sheet		Med/Tx Sheet		Date & Time	Communicated/Read Back
Pharmacy		Nurses Notes		Pt. Care Plan	Signed

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility			Address		
Family Name		First Name	Admission Number	Room No.	Attending Physician
Date Ordered	Time Ordered	Date Discontinued	Orders		
Signature of Nurse Receiving Order			<input type="checkbox"/> Resident Notified <input type="checkbox"/> Family Notified	Signature of Physician	
Initials			Initials	Initials	Date
On MD Order Sheet		Med/Tx Sheet		Date & Time	Communicated/Read Back
Pharmacy		Nurses Notes		Pt. Care Plan	Signed

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility			Address		
Family Name		First Name	Admission Number	Room No.	Attending Physician
Date Ordered	Time Ordered	Date Discontinued	Orders		
Signature of Nurse Receiving Order			<input type="checkbox"/> Resident Notified <input type="checkbox"/> Family Notified	Signature of Physician	
Initials			Initials	Initials	Date
On MD Order Sheet		Med/Tx Sheet		Date & Time	Communicated/Read Back
Pharmacy		Nurses Notes		Pt. Care Plan	Signed

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FAXED
10-18-12

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility			Address		
Family Name			First Name	Admission Number	Room No.
Date Ordered			Time Ordered	Date Discont.	Attending Physician
10-18-12			10:00 AM		Dr. Gora
Orders					
Cefazolin 300mg IV Q8hr x 2 weeks					
Flagyl 500mg IV Q8hr x 2 weeks					
Dr. Gora / V.O. Dr. Gora / V.O. Dr. Gora / V.O. Dr. Gora					
Signature of Nurse Receiving Order			Signature of Physician		
[Signature]			[Signature]		
Initials			Initials		
On MD Order Sheet			Med/Tx Sheet		
Pharmacy			Nurses Notes		
Date & Time			Pt. Care Plan		
Communicated / Read Back			Signed		

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10/18/12

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility			Address		
Family Name			First Name	Admission Number	Room No.
Date Ordered			Time Ordered	Date Discont.	Attending Physician
10/18/12			10:00 AM		Dr. Gora
Orders					
Tylenol Supp 150mg 1 PR Q6hr PRN					
for pain and fever					
Signature of Nurse Receiving Order			Signature of Physician		
[Signature]			[Signature]		
Initials			Initials		
On MD Order Sheet			Med/Tx Sheet		
Pharmacy			Nurses Notes		
Date & Time			Pt. Care Plan		
Communicated / Read Back			Signed		

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility			Address		
Family Name			First Name	Admission Number	Room No.
Date Ordered			Time Ordered	Date Discont.	Attending Physician
Orders					
Signature of Nurse Receiving Order			Signature of Physician		
Initials			Initials		
On MD Order Sheet			Med/Tx Sheet		
Pharmacy			Nurses Notes		
Date & Time			Pt. Care Plan		
Communicated / Read Back			Signed		

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PHYSICIAN'S TELEPHONE ORDERS

Name of Facility			Address		
Family Name <i>Coker Robert</i>			First Name	Admission Number	Room No. <i>501A</i>
Date Ordered			Time Ordered	Date Discont.	Attending Physician
10-17-12			3:40pm		
Signature of Nurse Receiving Order			Signature of Physician		
<i>[Signature]</i>			<i>[Signature]</i>		
Initials			Initials		
<i>EO</i>			<i>EO</i>		
On MD Order Sheet			Med/Tx Sheet		
<i>EO</i>			<i>EO</i>		
Pharmacy			Nurses Notes		
<i>EO</i>			<i>EO</i>		
Date & Time			Communicated / Read Back		
<i>EO</i>			<i>EO</i>		
Signed			Signed		
<i>EO</i>			<i>EO</i>		

ORDERS

CXR - dx congestion
stat CMP, CBC & diff + pH
hold pericoat

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PHYSICIAN'S TELEPHONE ORDERS

FAXED

Name of Facility			Address		
Family Name <i>Coker Robert</i>			First Name	Admission Number	Room No. <i>501A</i>
Date Ordered			Time Ordered	Date Discont.	Attending Physician
10-18-12			9:40am		
Signature of Nurse Receiving Order			Signature of Physician		
<i>[Signature]</i>			<i>[Signature]</i>		
Initials			Initials		
<i>EO</i>			<i>EO</i>		
On MD Order Sheet			Med/Tx Sheet		
<i>EO</i>			<i>EO</i>		
Pharmacy			Nurses Notes		
<i>EO</i>			<i>EO</i>		
Date & Time			Communicated / Read Back		
<i>EO</i>			<i>EO</i>		
Signed			Signed		
<i>EO</i>			<i>EO</i>		

ORDERS

Spulam for quad stain + C/S
chondamycin 500-300mg IV q 8h
x 2 weeks for pneumonia
do not resuscitate in the event of cardiac
arrest - son present

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PHYSICIAN'S TELEPHONE ORDERS

FAXED

Name of Facility			Address		
Family Name <i>Coker Robert</i>			First Name	Admission Number	Room No. <i>501A</i>
Date Ordered			Time Ordered	Date Discont.	Attending Physician
10-18-12			9:40am		
Signature of Nurse Receiving Order			Signature of Physician		
<i>[Signature]</i>			<i>[Signature]</i>		
Initials			Initials		
<i>EO</i>			<i>EO</i>		
On MD Order Sheet			Med/Tx Sheet		
<i>EO</i>			<i>EO</i>		
Pharmacy			Nurses Notes		
<i>EO</i>			<i>EO</i>		
Date & Time			Communicated / Read Back		
<i>EO</i>			<i>EO</i>		
Signed			Signed		
<i>EO</i>			<i>EO</i>		

ORDERS

IVF NS @ 50cc/hr x 2L
levagran 500mg IV q day x 2 weeks
for pneumonia

ORIGINAL COPY-Physician Please Sign and Return

ea/

Form 982/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2343

PHYSICIAN'S TELEPHONE ORDERS

Name of Facility LNRC			Address 110 Brandywine Blvd.		
Family Name Coker		First Name Robert	Admission Number	Room No. 501A	Attending Physician Goza
Date Ordered 10/17/12	Time Ordered	Date Discont.	Orders		
Diet order: D/C regular consistency + Δ to mechanical soft/chopped meats & thin liquids.					
T.O. Dr. Goza / C. [Signature]					
Signature of Nurse Receiving Order [Signature]			<input type="checkbox"/> Resident Notified <input type="checkbox"/> Family Notified		Signature of Physician [Signature]
Date 10/17/12					
On MD Order Sheet	Initials ea	Med/Tx Sheet	Initials ea	Date & Time	Initials ea
Pharmacy	Initials ea	Nurses Notes	Initials ea	Pt. Care Plan	Initials ea
				Communicated	Signed

ORIGINAL COPY-Physician Please Sign and Return

ea/

Form 982/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2343

PHYSICIAN'S TELEPHONE ORDERS

Name of Facility			Address		
Family Name Coker		First Name Robert	Admission Number	Room No. 501A	Attending Physician
Date Ordered 10-17-12	Time Ordered 525 pm	Date Discont.	Orders		
In house patient 10-18-12 dc [Signature] dc J. [Signature]					
Signature of Nurse Receiving Order [Signature]			<input type="checkbox"/> Resident Notified <input type="checkbox"/> Family Notified		Signature of Physician [Signature]
Date 10/17/12					
On MD Order Sheet	Initials ea	Med/Tx Sheet	Initials ea	Date & Time	Initials ea
Pharmacy	Initials ea	Nurses Notes	Initials ea	Pt. Care Plan	Initials ea
				Communicated / Read Back	Signed

ORIGINAL COPY-Physician Please Sign and Return

ea/

Form 982/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2343

PHYSICIAN'S TELEPHONE ORDERS

Name of Facility LNRC			Address		
Family Name Coker		First Name Robert	Admission Number	Room No. 501A	Attending Physician Dr. Goza
Date Ordered 10/17/12	Time Ordered 1730	Date Discont.	Orders		
Orally suction with Yankler for congestion in upper airway to initiate cough V.O. Dr. Goza / C. [Signature]					
Signature of Nurse Receiving Order [Signature]			<input type="checkbox"/> Resident Notified <input type="checkbox"/> Family Notified		Signature of Physician [Signature]
Date 10/18/12					
On MD Order Sheet	Initials ea	Med/Tx Sheet	Initials ea	Date & Time	Initials ea
Pharmacy	Initials ea	Nurses Notes	Initials ea	Pt. Care Plan	Initials ea
				Communicated / Read Back	Signed

ORIGINAL COPY-Physician Please Sign and Return



Medical Admission Unit
1255 Highway 54 West
Fayetteville, Georgia 30214
phone: 770.719.7455
piedmontfayette.org

Name: Coker, Robert DOB: 6/16/22

Address: _____ Date: 12/18/12

FRAGMIN
INJECT 18,000 units SQ daily
Seven (7) day supply
Refills: 7 d.s.

☐ Label

Refill:

DEA#:

NPI#:

Signature:

SRC120222C001314637-MV4798-01139




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**PIEDMONT
FAYETTE
HOSPITAL**

1255 Highway 54 West • MS3 SOUTH
Fayetteville, Georgia 30834

phone 800077790 DATE: _____
COKER, ROBERT
fax: 77 06/16/27 M 85Y TIME: _____
BRATHWAITE, PAULA
F1228100013 INITIALS: _____



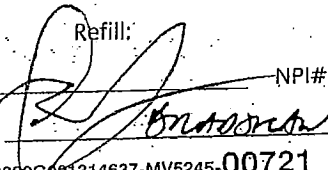
Name: _____ OB: _____

Address: _____ Date: 10/14/14


RECOCT 5/31/14 mg
TAKE 1-2 TABS PO Q6° PRN prn
40 Refills: zero (0)

☐ Label Refill: _____

DEA#: _____ NPI#: 1316107428

Signature:  _____

SRC120320C001314637-MV5245-00721



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PIEDMONT
FAYETTE
HOSPITAL

Medical Admission Unit
1255 Highway 54 West
Fayetteville, Georgia 30214
phone: 770.719.7455
piedmontfayette.org

Name: Coker, Robert DOB: 6/16/27

Address: _____ Date: 12/12/12

LOVENOX
INJECT 100mg SQ BID
SEVEN DAY SUPPLY
REFILLS: ZERO

☐ Label

Refill: _____

DEA#: _____

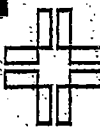

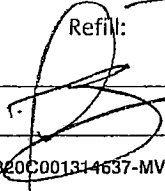

NPI#: _____

Signature: _____

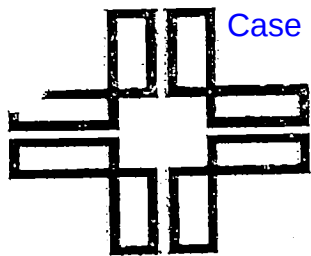
SRC1202226001314637-MV4798-01138



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 PIEDMONT FAYETTE HOSPITAL	
1255 Highway 54 West • MS3 SOUTH	
Fayetteville	800077790
phone	COKER, ROBERT
fax: 7:	06/16/27 M 85Y
	BRATHWAITE, PAULA
	F1228100013
	INITIALS: _____
	
Name: _____	OB: _____
Address: _____	Date: <u>10/16/14</u>
<p>① <u>WALFARM 7.5 mg</u> <u>Take TID daily</u> <u># 30 Refills: Two (2)</u></p> <p>② <u>METOPROLOL 25 mg</u> <u>Take TID BID</u> <u># 60 Refills: Three (3)</u></p>	
<input type="checkbox"/> Label	Refill: _____
DEA#: _____	NPI#: <u>1816107428</u>
Signature: 	
SRC120320C001314637-MV5245-00720	
	

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**PIEDMONT
FAYETTE
HOSPITAL**Discharge Medication Report

COKER, ROBERT
Attending Physician
Bradshaw, Mark R.

F-4 South-455-01
Admit
10/7/12 8:49 am

Age: 85

Male

MRN
800077790

Visit
1228100013

GenericDose**Home Medications to Continue**

<u>Generic</u>	<u>Brand</u>	<u>Dose</u>	<u>Frequency</u>	<u>Route</u>	<u>Instructions</u>
*carbidopa-levodopa tablet 10 mg-100 mg	Sinemet	1 tab(s)	4 times a day	oral	
*donepezil tablet		10 mg	once a day (at bedtime)	oral	
*nasteride tablet		5 mg	once a day	oral	
*rolic acid tablet		1 mg	once a day	oral	
*furosemide tablet		20 mg	once a day	oral	
*levothyroxine tablet	Levothroid	50 mcg	once a day	oral	
*memantine tablet	Namenda	5 mg	2 times a day	oral	
*mupirocin topical cream		1 app	3 times a day	applied topically	for 10days surgery 10/5/12
*ocular lubricant solution	Systane	1 gtt	4 times a day	ophthalmic	
*pantoprazole enteric coated tablet		40 mg	once a day	oral	
*potassium chloride capsule, extended release		10 mEq	once a day	oral	
*tamsulosin capsule		0.4 mg	once a day	oral	

Pro time
in house

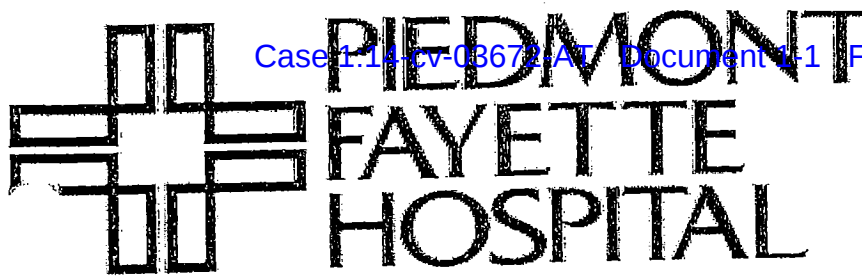
New Home Medications

<u>Generic</u>	<u>Brand</u>	<u>Dose</u>	<u>Frequency</u>	<u>Route</u>	<u>Instructions</u>
*Acetaminophen-OxycoDON E tablet		1 tablet(s)	every 6 hours	orally	As Needed For Pain - Moderate
*MetoPROLOL tartrate tablet		25 mg	2 times a day	orally	
*Warfarin tablet		7.5 mg	once a day	orally	

10-17-12

MRR Reconciled By Physician
Mark R. Bradshaw, MD

tylenol 650 x 2 PO q 6h prn pain
oxycodone 5x 1-2 PO q 6h
for pain not relieved by tylenol



Discharge Medication Report

COKER, ROBERT	F-4 South-455-01	Age: 85	Male
<u>Attending Physician</u>	<u>Admit</u>	<u>MRN</u>	<u>Visit</u>
Bradshaw, Mark R.	10/7/12 8:49 am	800077790	1228100013

<u>Generic</u>	<u>Dose</u>		
*Warfarin tablet	7.5 mg	once a day	orally

Follow-up with your Prescribing Physician on all home medications

MRR Reconciled By Physician

Mark R. Bradshaw, MD

PHYSICIAN'S PROGRESS NOTES

DATE	TIME	NOTES MUST BE SIGNED BY PHYSICIAN
10-18-12		<p>Internal Medicine family about</p> <p>⑤ Mr. Coker is seen in for congestion & somnolence. O₂ sat & today requiring 3L O₂ supplement</p> <p>⑥ 124/76 98 78 20</p> <p>Temp @ time of exam 102</p> <p>O₂ sat on 3L 91%</p> <p>elderly ♂ who remains somnolent</p> <p>upper airway congestion present -</p> <p>RT present to suction patient</p> <p>CXR @ for infiltrate</p> <p>hip incision - most exudate noted - no drainage</p> <p>⑦ hip pt</p> <p>fever</p> <p>⑧ VA/C+S</p> <p>Biquin acetamin & flagyl</p> <p>IVF</p> <p>Case discussed i son who requests DNR status</p> <p>W</p>

NAME-Last Coker	First Robert	Middle	Attending Physician	Record No.	Room/Bed
--------------------	-----------------	--------	---------------------	------------	----------

ADMISSION ORDERS RECORD

Medications Orders (Include diagnosis for each medication)		Admit to: <u>Kindred Healthcare Lafayette</u>	
2 step PPD to R/O TB		Orders Received by:	Admission Date: <u>10/16/12</u>
Assess for pain on 0-10 Pain scale every shift	7-3 scale	<input type="checkbox"/> I certify that post-hospital SNF services are required to be given on an in-patient basis because of the resident's need for skilled nursing or rehab care on a continuing basis for the condition(s) which required an in-patient hospital admission prior to transfer to the SNF.	
	3-11 scale	Resident is: <input type="checkbox"/> Capable <input type="checkbox"/> Incapable of making his/her own decisions	
	11-7 scale	Source: <input type="checkbox"/> Telephone <input type="checkbox"/> Verbal <input type="checkbox"/> Written <input type="checkbox"/> Transfer Form	
Sinemet 10mg/100mg one tablet by mouth four times daily for parkinson's disease	9AM 1PM 5PM 9PM	May Substitute a generic equivalent for all legend or non-legend medications: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Aricept 10mg one tablet by mouth once daily for dementia	9AM	Resident has been informed of current health status: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Why?	
Finasteride 5mg one tablet by mouth once daily for BPH	9AM	<input type="checkbox"/> If omeprazole PO caplets are ordered, substitute with over-the-counter (OTC) medication omeprazole OTC tablets. Except Kentucky and Indiana, have the pharmacy send Prilosec OTC.	
Folic acid 1mg one tablet by mouth once daily for anemia	9AM	Diet Order: <input type="checkbox"/> Regular <input checked="" type="checkbox"/> No Added Salt <input type="checkbox"/> Limited Concentrated Sweets <input type="checkbox"/> NPO <input type="checkbox"/> Heart Healthy <input type="checkbox"/> Other:	Texture: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Mechanical Soft <input type="checkbox"/> Dysphagia Mechanical <input type="checkbox"/> Puree <input type="checkbox"/> Other:
Lasix 20mg one tablet by mouth once daily for Afib	9AM	Liquids: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Nectar Thick <input type="checkbox"/> Honey Thick <input type="checkbox"/> Pudding/Spoon Thick	
INSTRUCTIONS (SEE REVERSE SIDE)		HOUR	
CHARTING FROM:		THRU:	
DIAGNOSIS		ALLERGIES	
Parkinson's Disease, HTN, Afib, hypothyroidism, dementia, C hip hemiarthoplasty, CA to skin		P-N, Cipro, Bactrim, sulfa, clindamycin	
PHYSICIAN <u>MD Gora</u>		TELEPHONE NO.	
RESIDENT NAME <u>Coker Robert</u>		MED REC NO.	
NURSE STA		ROOM/BED <u>501A</u>	
FACILITY <u>Kindred Healthcare Lafayette</u>		PAGE <u>1</u>	

ADMISSION ORDERS RECORD CONTINUATION

Synthroid 50mcg one tablet by mouth once daily for hypothyroidism	6AM	
namenda 5mg one tablet by mouth twice daily for alzheimer's disease	9AM 5pm	
Protonix enteric coated 40mg one tablet by mouth once daily for GERD's	10AM	
KCL ER 10mcg one capsule by mouth once daily for supplement	9AM	
Flomax 0.4mg one tablet by mouth once daily for BPH	9AM	
Cyslane 4 drop to both eyes four times daily for dry eyes	9AM 1PM 5PM 9PM	
Lopressor 25mg one tablet by mouth twice daily for HTN (hold for sbp <110 ; pulse <60)	9AM 3PM pulse 5PM B/P pulse	
Unless otherwise indicated, continue order(s) for 30 days for the first 90 days, and 60 days thereafter Nurse's Signature: <i>[Signature]</i> *Physician's Signature: <i>[Signature]</i> Orders Verified & Noted by: <i>[Signature]</i>		Date: 10/8/12 Date: 10/8/12 Date: 10/10/12
INSTRUCTIONS (SEE REVERSE SIDE)	HOUR	
DIAGNOSIS	CHARTING FROM:	THRU:
Parkinson's Disease, HTN, A-fib, hypothyroidism, dementia, hip hemiarthropathy GA to skin		
ALLERGIES	NURSE'S ALERT	
PCN, Cipro, Bactrim, sulfa clindamycin		
PHYSICIAN MD Goza	TELEPHONE NO.	ALT. PHYS.
RESIDENT NAME Ocker, Robert	MED REC NO.	ROOM/BED
	NURSE STA	FACILITY
		Kindred Healthcare Lafayette
		PAGE 2

ADMISSION ORDERS RECORD CONTINUATION

Coumadin 7.5mg one tablet by mouth daily for Afib	5 PM	
Lovenox 100mg injection SQ twice daily prophylactic x 7 days	9 AM	Hold + ID Clarified 10/16/12
Fragmin 18,000 units injection SQ daily prophylactic x 7 days	5 PM	
Call Dr. Brechtman for clarification of Lovenox order and Fragmin order this AM	9 AM	Hold for clarification 10/16/12
Tylenol 325mg 10 tablets PRN pain	F3	
Percocet 5/325mg one tablet by mouth every 4hrs as needed for mild pain	T-3	
Percocet 5/325mg two tablets by mouth every 4hrs as needed for severe pain	P R N	
INSTRUCTIONS (SEE REVERSE SIDE)		HOUR CHARTING FROM:
DIAGNOSIS Parkinson's Disease, HTN, Afib, hypothyroidism, dementia, hip hemiarthroplasty CA to skin		THRU: ALLERGIES PCN, Cipro, Bactrim, sulfa, Clindamycin
PHYSICIAN MD Goza RESIDENT NAME Coker, Robert		TELEPHONE NO. MED REC NO. NURSE STA ROOM/BED 301 A
ALT. PHYS. Kindred Health care (24hr)		ALT. TELEPHONE FACILITY PAGE 3

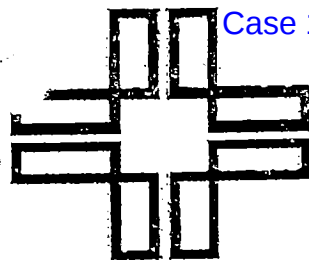
Unless otherwise indicated, continue order(s) for 30 days for the first 90 days, and 60 days thereafter

Nurse's Signature: *[Signature]* Date: 10/16/12

*Physician's Signature: *[Signature]* Date: 10/16/12

Orders Verified & Noted by: *[Signature]* Date: 10/16/12

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PIEDMONT FAYETTE HOSPITAL

Discharge Medication Report

COKER, ROBERT
Attending Physician
Bradshaw, Mark R.

F-4 South-455-01
Admit
10/7/12 8:49 am

Age: 85
MRN
800077790

Male
Visit
1228100013

Generic

Dose

Home Medications to Continue

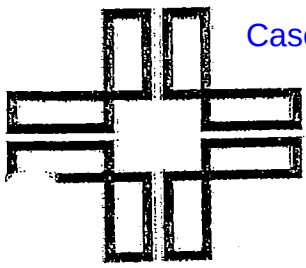
Generic	Brand	Dose	Frequency	Route	Instructions
*carbidopa-levodopa tablet 10 mg-100 mg	Sinemet	1 tab(s)	4 times a day	oral	
*donepezil tablet		10 mg	once a day (at bedtime)	oral	
*flunasteride tablet		5 mg	once a day	oral	
*folic acid tablet		1 mg	once a day	oral	
*furosemide tablet		20 mg	once a day	oral	
*levothyroxine tablet	Levothroid	50 mcg	once a day	oral	
*memantine tablet	Namenda	5 mg	2 times a day	oral	
*mupirocin topical cream		1 app	3 times a day	applied topically	for 10 days surgery 10/5/12
*ocular lubricant solution	Systane	1 gtt	4 times a day	ophthalmic	
*pantoprazole enteric coated tablet		40 mg	once a day	oral	
*potassium chloride capsule, extended release		10 mEq	once a day	oral	
*tamsulosin capsule		0.4 mg	once a day	oral	Pro time in house

New Home Medications

Generic	Brand	Dose	Frequency	Route	Instructions
*Acetaminophen-Oxycodon E tablet	5	1 tablet(s)	every 6 hours	orally	As Needed For Pain - Moderate
*Metoprolol tartrate tablet		25 mg	2 times a day	orally	
*Warfarin tablet		7.5 mg	once a day	orally	

MRR Reconciled By Physician
Mark R. Bradshaw, MD

tylenol 650 x 4 PO q 6h prn pain
oxycodone 5x 1-2 PO q 6h
for pain not relieved by tylenol

**PIEDMONT
FAYETTE
HOSPITAL**Discharge Medication Report

COKER, ROBERT
Attending Physician
Bradshaw, Mark R.

F-4 South-455-01

Admit
10/7/12 8:49 am

Age: 85
MRN
800077790

Male
Visit
1228100013

<u>Generic</u>	<u>Dose</u>
*Warfarin tablet	7.5 mg once a day orally

Follow-up with your Prescribing Physician on all home medications

PHYSICIAN'S PROGRESS NOTES

DATE	TIME	NOTES MUST BE SIGNED BY PHYSICIAN
10-18-12		<p>Internal Medicine - Family about</p> <p>⑤ Mr. Coker is seen in for congestion & somnolence. O₂ sat & today requiring 3L O₂ supplement</p> <p>⑥ 124/76 98 78 20</p> <p>Temp @ time of exam 102</p> <p>O₂ sat on 3L 91%</p> <p>elderly ♂ who remains somnolent</p> <p>upper airway congestion present -</p> <p>RT present to suction patient</p> <p>CXR ⊖ for infiltrate</p> <p>hip incision - most catheters removed - no drainage</p> <p>⑦ hip fx</p> <p>⑧ UA/G+S</p> <p>Bigen acetaminophen & fentanyl</p> <p>IVF</p> <p>Case discussed i son who requests DNR status</p> <p>W/O</p>

NAME-Last Coker	First Robert	Middle	Attending Physician	Record No.	F
--------------------	-----------------	--------	---------------------	------------	---

PointClickCare

Welcome Pamela Mosely | Logout | Help | Today is October 26, 2012

Kindred Transitional Care and Rehabilitation - Lafayette - 1228

Home Admin Clinical

Quick ADT New Patient New Medical Professional Manage Users

Patients

Dashboard

Quick Entry

Weights and Vitals

MDS 2.0 and 3.0 Mgmt

UDA

Communications

Reports

Setup

Logout

Help

Resource Center / Support

Patient Search

by: Last Name

Go

Search all Facilities

Coker, Robert (123986) edit photo n

Status: Discharged

Unit/Room/Bed: - Initial Admission Date (MDS): 10/16/2012

Birth Date: 6/16/1927 Admission (Re-entry): 10/16/2012

Gender: Male Discharge Date: 10/19/2012

Enterprise ID: 24065

Allergies: PCN,CIPRO,BACTRIM,SULFA,CLINDAMYCIN edit

Dash Profile Census Med Diag Immun Vitals/Vitals MDS Assmt Prog Note Care Plan Tasks

Immunizations New

Immunization Report

Immunization	Date	Status	Administered By
edit del sleep2 TB 2 Step Mantoux Skin Test (Step 1)	10/16/2012	Results Pending	Jennifer Smith-Franklin

10 of 36

Previous Next

Jump to: Admin

PointClickCare Version 3.6.1.0.5 - KIND-040009-040009
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MINIMUM DATA SET (MDS) - Version 3.0 **RESIDENT ASSESSMENT AND CARE SCREENING** **Nursing Home and Swing Bed Tracking (NT/ST) Item Set**

Section A		Identification Information	
A0050. Type of Record			
Enter Code		1. Add new record → Continue to A0100, Facility Provider Numbers 2. Modify existing record → Continue to A0100, Facility Provider Numbers 3. Inactivate existing record → Skip to X0150, Type of Provider	
	<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">1</div>		
A0100. Facility Provider Numbers			
A. National Provider Identifier (NPI): <div style="border: 1px solid black; padding: 2px; display: flex; gap: 5px;"> 1 7 4 0 3 6 8 6 1 2 </div>			
B. CMS Certification Number (CCN): <div style="border: 1px solid black; padding: 2px; display: flex; gap: 5px;"> 1 1 5 3 6 0 </div>			
C. State Provider Number: <div style="border: 1px solid black; padding: 2px; display: flex; gap: 5px;"> 0 0 3 9 9 7 3 7 A </div>			
A0200. Type of Provider			
Enter Code		Type of provider	
	<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">1</div>	1. Nursing home (SNF/NF) 2. Swing Bed	
A0310. Type of Assessment			
Enter Code		A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above	
	<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">9</div> <div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">9</div>		
Enter Code		B. PPS Assessment <u>PPS Scheduled Assessments for a Medicare Part A Stay</u> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment <u>PPS Unscheduled Assessments for a Medicare Part A Stay</u> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <u>Not PPS Assessment</u> 99. None of the above	
	<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">9</div> <div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">9</div>		
Enter Code		C. PPS Other Medicare Required Assessment - OMRA 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment	
	<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">0</div>		
Enter Code		D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2 0. No 1. Yes	
	<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;"> </div>		
A0310 continued on next page			

Section A Identification Information	
A0310. Type of Assessment - Continued	
Enter Code: <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">0</div>	E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? 0. No 1. Yes
Enter Code: <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">0 1</div>	F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above
Enter Code: <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;"></div>	G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned
A0410. Submission Requirement	
Enter Code: <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">3</div>	1. Neither federal nor state required submission 2. State but not federal required submission (FOR NURSING HOMES ONLY) 3. Federal required submission
A0500. Legal Name of Resident	
A. First name: <div style="border: 1px solid black; display: inline-block; padding: 2px;">R o b e r t</div>	B. Middle initial: <div style="border: 1px solid black; display: inline-block; width: 20px; height: 15px; margin: 2px;"></div>
C. Last name: <div style="border: 1px solid black; display: inline-block; padding: 2px;">C o k e r</div>	D. Suffix: <div style="border: 1px solid black; display: inline-block; padding: 2px;"> </div>
A0600. Social Security and Medicare Numbers	
A. Social Security Number: <div style="border: 1px solid black; display: inline-block; padding: 2px;">2 5 3 - 3 4 - 8 5 3 2</div>	
B. Medicare number (or comparable railroad insurance number): <div style="border: 1px solid black; display: inline-block; padding: 2px;">2 5 3 3 4 8 5 3 2 A</div>	
A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient	
<div style="border: 1px solid black; display: inline-block; padding: 2px;"> </div>	
A0800. Gender	
Enter Code: <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">2</div>	1. Male 2. Female
A0900. Birth Date	
<div style="border: 1px solid black; display: inline-block; padding: 2px;">0 6 - 1 6 - 1 9 2 7</div> <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>	
A1000. Race/Ethnicity	
↓ Check all that apply	
<input type="checkbox"/>	A. American Indian or Alaska Native
<input type="checkbox"/>	B. Asian
<input type="checkbox"/>	C. Black or African American
<input type="checkbox"/>	D. Hispanic or Latino
<input type="checkbox"/>	E. Native Hawaiian or Other Pacific Islander
<input type="checkbox"/>	F. White

Section A Identification Information	
A1200. Marital Status	
Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin: 5px;">-</div>	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced
A1300. Optional Resident Items	
A. Medical record number: <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">3</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">9</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">6</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">5</div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	
B. Room number: <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	
C. Name by which resident prefers to be addressed: <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	
D. Lifetime occupation(s) - put "/" between two occupations: <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	
A1600. Entry Date (date of this admission/entry or reentry into the facility)	
<div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</div> <div style="font-size: 10px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">6</div> <div style="font-size: 10px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 5px;"> Month Day Year </div>	
A1700. Type of Entry	
Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin: 5px;">1</div>	1. Admission 2. Reentry
A1800. Entered From	
Enter Code <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">3</div> </div>	01. Community (private home/apt., board/care, assisted living, group home) 02. Another nursing home or swing bed 03. Acute hospital 04. Psychiatric hospital 05. Inpatient rehabilitation facility 06. ID/DD facility 07. Hospice 09. Long Term Care Hospital (LTCH) 99. Other
A2000. Discharge Date	
Complete only if A0310F = 10, 11, or 12	
<div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="font-size: 10px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="font-size: 10px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 5px;"> Month Day Year </div>	
A2100. Discharge Status	
Complete only if A0310F = 10, 11, or 12	
Enter Code <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	01. Community (private home/apt., board/care, assisted living, group home) 02. Another nursing home or swing bed 03. Acute hospital 04. Psychiatric hospital 05. Inpatient rehabilitation facility 06. ID/DD facility 07. Hospice 08. Deceased 09. Long Term Care Hospital (LTCH) 99. Other

Section A Identification Information

A2400. Medicare Stay

Enter Code

1

A. Has the resident had a Medicare-covered stay since the most recent entry?

- 0. **No** → Skip to Section X, Correction Request
- 1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

1	0	-	1	6	-	2	0	1	2
Month		Day		Year					

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

-	-	-	-	-	-	-	-
Month		Day		Year			

Correction Request

Identification of Record to be Modified/Inactivated – The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

1. Nursing home (SNF/NF)
2. Swing Bed

[illegible]

1. Male
2. Female

		-			-				
Month			Day			Year			

--	--	--	--

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction to prior comprehensive** assessment
06. **Significant correction to prior quarterly** assessment
99. **None of the above**

07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
 99. None of the above

0. No
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment
4. **Change of therapy** assessment

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Section X**Correction Request****X0600. Type of Assessment - Continued**

Enter Code

☐**D. Is this a Swing Bed clinical change assessment?** Complete only if X0150 = 2

0. No
1. Yes

Enter Code

☐**F. Entry/discharge reporting**

01. Entry tracking record
10. Discharge assessment-return not anticipated
11. Discharge assessment-return anticipated
12. Death in facility tracking record
99. None of the above

X0700. Date on existing record to be modified/inactivated - Complete one only**A. Assessment Reference Date** - Complete only if X0600F = 99

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

B. Discharge Date - Complete only if X0600F = 10, 11, or 12

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

C. Entry Date - Complete only if X0600F = 01

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request**X0800. Correction Number**

Enter Number

Enter the number of correction requests to modify/inactivate the existing record, including the present one

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2)

↓ Check all that apply

☐**A. Transcription error**☐**B. Data entry error**☐**C. Software product error**☐**D. Item coding error**☐**E. End of Therapy - Resumption (EOT-R) date**☐**Z. Other error requiring modification**

If "Other" checked, please specify: _____

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3)

↓ Check all that apply

☐**A. Event did not occur**☐**Z. Other error requiring inactivation**

If "Other" checked, please specify: _____

Section X	Correction Request
X1100. RN Assessment Coordinator Attestation of Completion	
A.	Attesting individual's first name: <div style="border: 1px solid black; height: 1.2em; width: 100%; margin-top: 5px;"></div>
B.	Attesting individual's last name: <div style="border: 1px solid black; height: 1.2em; width: 100%; margin-top: 5px;"></div>
C.	Attesting individual's title: <div style="border: 1px solid black; height: 1.2em; width: 100%; margin-top: 5px;"></div>
D.	Signature <div style="border: 1px solid black; height: 1.2em; width: 100%; margin-top: 5px;"></div>
E.	Attestation date <div style="display: flex; align-items: center; margin-top: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: 0.8em; margin-top: 2px;"> Month Day Year </div>

Section Z**Assessment Administration****Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting**

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A. Melinda Bray [ESOF]	LPN, RAC-CT	A	10-22-2012
B.			
C.			

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Patient Name: Robert Coker Patient Number: 123966 Effective Date: 10/19/2012 14:40
 Location: 1-5 501 A Admission Date: 10/16/2012 Date of Birth: 6/16/1927
 Gender: M Physician: WENDY GOZA
 Allergies: PCN,GIPRO,BACTRIM,SULFA,CLINDAMYCIN
 Diagnosis: NA
 Title: Medical Nutrition Therapy Assessment (Version 3.0)

A.	Type of Assessment	<p>A1. Type of Assessment 0) Admission 1) Annual 2) Change Of Condition</p> <p>A2. Enter most recent Malnutrition Screening Tool score from Patient Nursing Evaluation 5</p> <p>A3. Based on the score, choose the malnutrition risk category (score of 2 or more = risk for malnutrition) <input type="radio"/> 1. No risk for malnutrition <input checked="" type="radio"/> 2. Risk for malnutrition</p>
B.	Food/Nutrition Related History	<p>Diet order: Check all that apply:</p> <p>1. <input type="checkbox"/> Regular 2. <input checked="" type="checkbox"/> No Added Salt (NAS) 3. <input type="checkbox"/> Limited Concentrated Sweets 4. <input type="checkbox"/> Heart Healthy 5. <input type="checkbox"/> 80 gm Protein, 3 gm K+, 2-3 gm Na+ 6. <input type="checkbox"/> 1500 Calorie 7. <input type="checkbox"/> 1800 Calorie 8. <input type="checkbox"/> Gluten Free 9. <input type="checkbox"/> Enteral Nutrition: If checked complete section H (Enteral Nutrition Orders) of this assessment. 10. <input type="checkbox"/> Parenteral Nutrition: If checked, refer to Parenteral Nutrition Worksheet for nutrient calculations. 11. <input type="checkbox"/> NPO 12. <input type="checkbox"/> Other 12a. Other (specify)</p>
C.	Food/Nutrition Related History	<p>1. Food Consistency/Texture 0) No alteration in texture 1) Mechanical soft 2) Dysphagia mechanical 3) Pureed 4) Finger food mechanical soft 5) Finger food 6) Other 1a. If other food consistency/texture (specify)</p> <p>2. Liquid Consistency 0) No restrictions 1) Nectar thick 2) Honey thick 3) Spoon/pudding thick</p> <p>3. Portion size</p>

<p>C. Food/Nutrition Related History</p>	<p>0) Standard 1) Small 2) Large 3) Other</p> <p>3a. If other portion size (specify) <input type="text"/></p>
	<p>4. Fluid restriction 0) No restriction 1) 1000 ml 2) 1500 ml 3) 1800 ml 4) 2000 ml 5) Other</p> <p>4a. If other fluid restriction (specify) <input type="text"/></p>
	<p>5. Does patient receive medical food supplements? <input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes</p>
	<p>C1. Medical Food Supplement #1 C1a. Choose which applies 1) 1.5 cal/ml 2) 2.0 cal/ml 3) Fortified shake 4) Fortified shake, honey consistency 5) Fortified juice drink 6) Nepro 7) Suplena 8) Protein modular 9) Arginine supplement powder 10) Fortified cookie 11) Fortified Pudding 12) Other</p> <p>C1b. Other (specify) <input type="text"/></p>
	<p>Frequency C1c. Choose which applies: 1) One time per day 2) Two times per day 3) Three times per day 4) Four times per day 5) Five times per day 6) Six times per day 7) Other</p> <p>C1d. If other frequency: (specify) <input type="text"/></p>
	<p>Additional information, if applicable (e.g., brand name, amount, serving times) C1e. <input type="text"/></p>
	<p>C2. Medical Food Supplement #2 C2a. <input type="text"/></p>

C.	Food/Nutrition Related History	<div data-bbox="483 86 852 409"> <p>1) 1.5 cal/ml 2) 2.0 cal/ml 3) Fortified shake 4) Fortified shake, honey consistency 5) Fortified juice drink 6) Nepro 7) Suplena 8) Protein modular 9) Arginine supplement powder 10) Fortified cookie 11) Fortified Pudding 12) Other C2b. Other (specify)</p> </div> <div data-bbox="349 609 755 856"> <p>Frequency C2c. Choose which applies: 1) One time per day 2) Two times per day 3) Three times per day 4) Four times per day 5) Five times per day 6) Six times per day 7) Other C2d. If other frequency (specify)</p> </div> <div data-bbox="349 1045 1307 1108"> <p>Additional information, if applicable (e.g., brand name, amount, serving times) C2e.</p> </div> <div data-bbox="349 1302 868 1680"> <p>C3. Medical Food Supplement #3 C3a. 1) 1.5 cal/ml 2) 2.0 cal/ml 3) Fortified shake 4) Fortified shake, honey consistency 5) Fortified juice drink 6) Nepro 7) Suplena 8) Protein modular 9) Arginine supplement powder 10) Fortified cookie 11) Fortified Pudding 12) Other C3b. Other (specify)</p> </div> <div data-bbox="349 1879 487 1906"> <p>Frequency</p> </div>
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C. Food/Nutrition Related History	<p>C3c. Choose which applies:</p> <ol style="list-style-type: none">1) One time per day2) Two times per day3) Three times per day4) Four times per day5) Five times per day6) Six times per day7) Other <p>C3d. If other frequency (specify)</p> <p>Additional information, if applicable (e.g., brand name, amount, serving times)</p> <p>C3e.</p> <p>Snacks: In addition to general snacks, does the patient have an individualized snack schedule?</p> <p>C4.</p> <p><input checked="" type="radio"/> 0. No</p> <p><input type="radio"/> 1. Yes</p> <p>C4a. If yes describe:</p> <div style="border: 1px solid black; height: 15px; width: 400px;"></div> <p>C5. Average Food/Beverage Intake:</p> <p><input checked="" type="radio"/> 0. Averaging 50% or less in past 7 days</p> <p><input type="radio"/> 1. Averaging more than 50% in past 7 days</p> <p><input type="radio"/> 2. Not applicable</p> <p>C6. Average Medical Food Supplement Intake</p> <p><input type="radio"/> 0. Averaging 50% or less in past 7 days</p> <p><input type="radio"/> 1. Averaging more than 50% in past 7 days</p> <p><input checked="" type="radio"/> 2. Not applicable</p>
CC. Food/Nutrition Related History	<p>C2. Food Allergies: Choose all that apply</p> <p>2A. <input checked="" type="checkbox"/> NKFA</p> <p>2B. <input type="checkbox"/> Shellfish</p> <p>2C. <input type="checkbox"/> Eggs</p> <p>2D. <input type="checkbox"/> Milk</p> <p>2E. <input type="checkbox"/> Peanuts</p> <p>2F. <input type="checkbox"/> Soy</p> <p>2G. <input type="checkbox"/> Tree Nuts</p> <p>2H. <input type="checkbox"/> Wheat</p> <p>2I. <input type="checkbox"/> Other</p> <p>2ia. Other (specify)</p> <div style="border: 1px solid black; height: 15px; width: 150px;"></div> <p>C3. Food Intolerance: Choose all that apply</p> <p>3A. <input checked="" type="checkbox"/> NKFI</p> <p>3B. <input type="checkbox"/> Lactose</p> <p>3C. <input type="checkbox"/> Caffeine</p> <p>3D. <input type="checkbox"/> Other</p> <p>3E. Other (specify)</p>

CC. Food/Nutrition Related History	<p>C5. Religious/Cultural/Ethnic Food Preferences (list) none</p> <p>C6. Avoidance of one or more food groups (list) no</p> <p>C7. Food preferences on record <input type="radio"/> 0. No <input checked="" type="radio"/> 1. Yes <input type="radio"/> 2. Not applicable </p> <p>C8. Other diet history information: Per patient's son, patient ate well PTA while in hospital, hx of good p.o. Intake, no wt loss.</p> <p>C9. Relevant medications and herbal supplements : IVFs, IV Abt, Coumadin, Lactobacillus, Lasix, Sinemet, Folic Acid, Protonix, KCl, Synthroid, others noted</p>
D. Nutrition-Focused Physical Findings	<p>Skin</p> <p>1A. Pressure Ulcer Risk, most recent date of completion by nursing. 10/16/2012</p> <p>1B. Risk level (per nursing assessment) <input type="radio"/> 0) Braden-Not at Risk (19-23) <input type="radio"/> 1) Braden-At Risk (15-18) <input type="radio"/> 2) Braden-Moderate Risk (13-14) <input checked="" type="radio"/> 3) Braden-High Risk (10-12) <input type="radio"/> 4) Braden-Very High Risk (0-9) <input type="radio"/> 5) Norton-Low Risk (16-20) <input type="radio"/> 6) Norton-Moderate Risk (11-15) <input type="radio"/> 7) Norton-High Risk (-3-10) </p> <p>1E. Are there any Pressure Ulcers/Wounds/Skin Problems <input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes </p> <p>1F. If Yes: List Skin Concerns</p> <p>Oral Health-Check all that apply-obtain information from the most recent nursing assessment</p> <p>2A. <input checked="" type="checkbox"/> Oral mucosa moist, pink, without lesions or ulcerations, good oral hygiene</p> <p>2B. <input type="checkbox"/> Oral Discomfort/Pain</p> <p>2C. <input type="checkbox"/> Caries/Decay</p> <p>2D. <input type="checkbox"/> Candida</p> <p>2E. <input type="checkbox"/> Inflamed/Bleeding gums</p> <p>2F. <input type="checkbox"/> Ulcers/Lesions</p> <p>2G. <input type="checkbox"/> Missing Teeth</p> <p>2H. <input type="checkbox"/> Edentulous/No natural teeth/Tooth fragments</p> <p>2Ha. <input type="checkbox"/> No oral health issues</p> <p>2I. Does patient have partial dentures? <input type="radio"/> 0. No <input checked="" type="radio"/> 1. Yes </p> <p>2Ia. Does patient have full dentures? <input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes </p> <p>2J. Are there any concerns with dentures: Choose below.</p> <p>2J1. <input type="checkbox"/> Fit</p> <p>2J2. <input checked="" type="checkbox"/> Loose/ill fitting</p> <p>2J3. <input type="checkbox"/> Broken/chipped</p>

D.

Nutrition-Focused Physical Findings

2J4. ☐ No concerns

Swallowing Disorder

K0100. Does the patient have signs and symptoms of a possible swallowing disorder. If yes-choose all that apply: 2N1 through 2N4 below are MDS question K0100A, K0100B, K0100C, K0100D

☐ 0. No

☒ 1. Yes

2N1. ☐ Loss of liquids/solids from mouth when eating or drinking

2N2. ☐ Holding food in mouth/cheeks or residual food in mouth after meals

2N3. ☐ Coughing or choking during meals or when swallowing medications

2N4. ☒ Complaints of difficulty or pain when swallowing

2N6. Other oral/mouth problem

☒ 0. No ☐ 1. Yes

2N7. If other (specify)

Ambulation (check all that apply)-obtain information from the most recent nursing assessment

3A. ☐ Ambulatory

3B. ☐ Walker/cane/crutch

3C. ☐ Wheelchair

3D. ☐ Paces/wanders

3E. ☒ Chair/bedfast

3F. ☐ Scooter

Dining Skills. Choose highest level of dependence. Obtain information from the most recent nursing assessment.

4A. ☐ Independent

4B. ☐ Supervision

4C. ☐ Limited Assist

4D. ☐ Extensive Assist

4E. ☒ Total Dependence

4F. Adaptive eating equipment

☒ 0. No

☐ 1. Yes

If yes to adaptive eating equipment, choose all that apply:

4f1. ☐ Plate guard

4f2. ☐ High sided plate

4f3. ☐ Scoop plate

4f4. ☐ Noseycup

4f5. ☐ 2-handle cup

4f6. ☐ Provale cup

4f7. ☐ Sippy cup

4f8. ☐ Plastic coated utensils

4f9. ☐ Weighted utensils

4f10. ☐ Built-up utensil handles

4f11. ☐ Swivel utensils

4f12. ☐ Elongated utensils

4f13. ☐ Requires a straw

4f14. ☐ Other

4f15. If other (specify)

Other Nutrition Assessment Data6A. ☐ Communication/Comprehension Impairment

61a. Communication/Comprehension Impairment (specify)

61b. ☐ Non-English speaking

61c. If Non-English speaking, specify language.

6B. ☐ Hearing impairment

6Bb. Hearing impairment (specify)

6C. ☐ Vision impairment

6Cc. Vision impairment (specify)

6D. ☐ Amputee

6E. If Amputee specify which limb

6F. ☐ Colostomy6G. ☐ Constipation6H. ☐ Diarrhea6I. ☐ Vomiting6J. ☐ Fever6K. ☐ Edema6L. ☐ Dialysis

6M. Type and frequency of Dialysis

D.	Nutrition-Focused Physical Findings	<p>6N. <input type="checkbox"/> Other</p> <p>6Na. If other (specify)</p>
E.	Biochemical Data, Medical Tests, Procedures	<p>Enter test date and results of most recent labs listed below:</p> <p>1A. <input checked="" type="checkbox"/> Sodium mEq/L</p> <p>1B. Date Sodium lab completed: 10/17/2012</p> <p>1C. Results of Sodium Lab: 144</p> <p>1D. Range of lab <input checked="" type="radio"/> 0. Normal <input type="radio"/> 1. High <input type="radio"/> 2. Low</p> <p>2A. <input checked="" type="checkbox"/> Potassium mEq/L</p> <p>2B. Date Potassium lab completed: 10/17/2012</p> <p>2C. Results of Potassium Lab: 4.4</p> <p>2D. Range of lab <input checked="" type="radio"/> 0. Normal <input type="radio"/> 1. High <input type="radio"/> 2. Low</p> <p>3A. <input checked="" type="checkbox"/> Blood Glucose mg/dL</p> <p>3B. Date Blood Glucose lab completed: 10/17/2012</p> <p>3C. Results of Blood Glucose Lab: 86</p> <p>3D. Range of lab <input checked="" type="radio"/> 0. Normal <input type="radio"/> 1. High <input type="radio"/> 2. Low</p> <p>4A. <input checked="" type="checkbox"/> BUN mg/dL</p> <p>4B. Date BUN lab completed: 10/17/2012</p> <p>4C. Results of BUN Lab: 26</p> <p>4D. Range of lab <input type="radio"/> 0. Normal <input checked="" type="radio"/> 1. High <input type="radio"/> 2. Low</p> <p>8A. <input checked="" type="checkbox"/> Creatinine mg/dL</p> <p>8B. Date of Creatinine Lab: 10/17/2012</p> <p>8C. Results of Creatinine Lab: 1.1</p> <p>8D. Range of Lab <input checked="" type="radio"/> 0. Normal <input type="radio"/> 1. High <input type="radio"/> 2. Low</p> <p>5A. <input type="checkbox"/> Phosphorous mg/dL</p> <p>5B. Date of Phosphorous Lab:</p>

E.

**Biochemical
Data, Medical
Tests,
Procedures**

5C. Results of Phosphorous lab:

5D. Range of lab

☐ 0. Normal ☐ 1. High ☐ 2. Low

6A. ☒ Hemoglobin g/dL

6B. Date of Hemoglobin lab:

10/17/2012

6C. Results of Hemoglobin lab:

12.8

6D. Range of lab

☐ 0. Normal ☐ 1. High ☒ 2. Low

7A. ☐ Hematocrit %

7B. Date of Hematocrit lab:

7C. Results of Hematocrit lab:

7D. Range of Lab

☐ 0. Normal ☐ 1. High ☐ 2. Low

9A. ☐ B12 pg/mL

9B. Date of B12

9C. Results of B12 lab:

9D. Range of Lab

☐ 0. Normal ☐ 1. High ☐ 2. Low

10A. ☐ Folate ng/mL

10B. Date of Folate lab:

10C. Results of Folate lab:

10D. Range of Lab

☐ 0. Normal ☐ 1. High ☐ 2. Low

11A. ☐ HbA1C %

11B. Date of HgbA1C

11C. Results of HgbA1C:

11D. Range of lab

☐ 0. Normal ☐ 1. High ☐ 2. Low

12A. ☒ Albumin gm/dL

12B. Date of Albumin lab:

10/17/2012

12C. Results of Albumin lab:

2.9

12D. Range of Lab

☐ 0. Normal ☐ 1. High ☒ 2. Low

13A. ☐ Pre-Albumin mg/dL

13B. Date of Pre-Albumin lab:

13C. Results of Pre-Albumin lab:

13D. Range of Lab

☐ 0. Normal ☐ 1. High ☐ 2. Low

14A. ☐ Cholesterol mg/dL

E.	Biochemical Data, Medical Tests, Procedures	<p>14B. Date of Cholesterol lab: <input type="text"/></p> <p>14C. Results of Cholesterol lab: <input type="text"/></p> <p>14D. Range of Lab <input type="radio"/> 0. Normal <input type="radio"/> 1. High <input type="radio"/> 2. Low</p> <p>15A. <input type="checkbox"/> Other lab: 15B. Other lab (specify) <input type="text"/></p> <p>15C. Date of other lab: <input type="text"/></p> <p>15D. Other lab results: <input type="text"/></p> <p>15E. Range of lab <input type="radio"/> 0. Normal <input type="radio"/> 1. High <input type="radio"/> 2. Low</p> <p>16A. <input type="checkbox"/> Other lab: 16B. Other lab (specify) <input type="text"/></p> <p>16C. Date of other lab: <input type="text"/></p> <p>16D. Other lab results: <input type="text"/></p> <p>16E. Range of lab: <input type="radio"/> 0. Normal <input type="radio"/> 1. High <input type="radio"/> 2. Low</p> <p>17A. <input type="checkbox"/> Other lab: 17B. Other lab (specify) <input type="text"/></p> <p>17C. Date of other lab: <input type="text"/></p> <p>17D. Results of other lab: <input type="text"/></p> <p>17E. Range of lab: <input type="radio"/> 0. Normal <input type="radio"/> 1. High <input type="radio"/> 2. Low</p> <p>18. Other relevant tests or procedures? <input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes</p> <p>18a. If other relevant biochemical data, medical tests, or procedures: List dates and results</p>
F.	Anthropometric Measurements	<p>F1. Age: <input type="text" value="85"/></p> <p>F2. Most Recent Height Height: <u>71</u> Date: <u>10/16/2012 14:48</u> Method: <u>Lying down</u> <i>Click on view to see weights for this patient. If a weight was taken in conjunction with this review, click on new to enter the weight into the record. Record weight in pounds.</i></p> <p>3. Most Recent Weight Weight: <u>219.5</u> Date: <u>10/16/2012 18:01</u> Scale: <u>Wheelchair</u></p> <p>F3a. Convert weight in pounds to kilograms and record below.</p>

F. Anthropometric Measurements	<div style="display: flex; justify-content: space-between;"> <div style="width: 15%;"> <p>F4.</p><p>F5.</p><p>F6.</p><p>F7.</p><p>F8.</p><p>F9.</p><p>F10.</p><p>F10a.</p><p>F11.</p><p>F11a.</p><p>F12.</p><p>12a.</p> </div> <div style="width: 85%;"> <div style="border: 1px solid black; width: 80px; height: 15px; margin-bottom: 5px;"></div> <p>BMI</p> <div style="border: 1px solid black; width: 80px; height: 15px; margin-bottom: 5px;"></div> <p>Physician Prescribed Wt Loss Regimen?</p> <p><input checked="" type="radio"/> 0. No</p> <p><input type="radio"/> 1. Yes</p> <p>Go to the Weights/Vitals tab or portal to view the Weight Summary for this resident. The heading of the weight summary contains the IBW Range. Enter the values listed</p> <div style="border: 1px solid black; width: 80px; height: 15px; margin-bottom: 5px;"></div> <p>IBW (+/-10%)</p> <p>%IBW</p> <div style="border: 1px solid black; width: 80px; height: 15px; margin-bottom: 5px;"></div> <p>UBW Range (pounds)</p> <div style="border: 1px solid black; width: 150px; height: 15px; margin-bottom: 5px;"></div> <p>%UBW</p> <div style="border: 1px solid black; width: 80px; height: 15px; margin-bottom: 5px;"></div> <p>View past weights - choose the weight in the record representative of time frame specified.</p> <p>Weight 1 month ago.</p> <p>Most Recent Weight</p> <p>Weight: Date:</p> <p>Scale:</p> <p>Weight 3 months ago</p> <p>Most Recent Weight</p> <p>Weight: Date:</p> <p>Scale:</p> <p>Weight 6 months ago</p> <p>Most Recent Weight</p> <p>Weight: Date:</p> <p>Scale:</p> </div> </div>
G. Comparative Standards: Estimated Energy, Protein, Fluid Needs	<p>G1. Method for estimating energy needs. Check all that apply:</p> <p>G1a. <input checked="" type="checkbox"/> 20 kcal/kg</p> <p>G1b. <input type="checkbox"/> 25 kcal/kg</p> <p>G1c. <input type="checkbox"/> 30 kcal/kg</p> <p>G1d. <input type="checkbox"/> 35 kcal/kg</p> <p>G1e. <input type="checkbox"/> Mifflin St Jeor</p> <p>Mifflin St. Jeor Equation:</p> <p>G1ee. Men: $10 \times \text{weight (kg)} + 6.25 \times \text{height (cm)} - 5 \times \text{age (y)} + 5$</p> <p>Women: $10 \times \text{weight (kg)} + 6.25 \times \text{height (cm)} - 5 \times \text{age (y)} - 161$</p> <p>G1f. <input type="checkbox"/> Harris Benedict</p> <p>Harris Benedict Equation:</p> <p>G1ff. Men: $66.5 + (13.75 \times \text{weight in kg}) + (5.003 \times \text{height in cm}) - (6.775 \times \text{age in years})$</p> <p>Women: $655.1 + (9.563 \times \text{weight in kg}) + (1.85 \times \text{height in cm}) - (4.676 \times \text{age in years})$</p> <p>G1g. Total energy estimated needs.</p> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 5px;"></div> <p>G1. Method for estimating protein needs. Check all that apply:</p> <p>G2a. <input type="checkbox"/> 0.8 g/kg</p> <p>G2b. <input checked="" type="checkbox"/> 1.0 g/kg</p> <p>G2c. <input type="checkbox"/> 1.2 g/kg</p> <p>G2d. <input type="checkbox"/> 1.5 g/kg</p> <p>G2e. <input type="checkbox"/> 2 g/kg</p>

G.	Comparative Standards: Estimated Energy, Protein, Fluid Needs	<p>G2f. Total protein estimated needs. <div style="border: 1px solid black; padding: 2px;">81 g pro (per kg IBW)</div> </p> <p>G3. Method for estimating fluid needs. Check all that apply:</p> <p>G3a. <input type="checkbox"/> ((wt in kg-20)*15+1500)</p> <p>G3b. <input checked="" type="checkbox"/> 20 ml/kg</p> <p>G3C. <input checked="" type="checkbox"/> 25 ml/kg</p> <p>G3d. <input type="checkbox"/> 30 ml/kg</p> <p>G3e. <input type="checkbox"/> 35 ml/kg</p> <p>G3f. Total fluid estimated needs. <div style="border: 1px solid black; padding: 2px;">2.0-2.5 L</div> </p> <p>G4. Weight used for calculations (Choose what applies)</p> <p>G4a. <input checked="" type="checkbox"/> Actual</p> <p>G4b. <input checked="" type="checkbox"/> IBW</p> <p>G4c. <input type="checkbox"/> UBW</p> <p>G4d. <input type="checkbox"/> Adjusted (specify)</p> <p>G4e. Adjusted body weight in pounds. (specify) <div style="border: 1px solid black; padding: 2px; width: 100px;"></div> </p>
H.	Enteral Nutrition Orders	<p>Enteral nutrition is medically necessary due to (check all that apply):</p> <p>H1a. <input type="checkbox"/> Dysphagia</p> <p>H1b. <input type="checkbox"/> Esophageal Paralysis</p> <p>H1c. <input type="checkbox"/> Malabsorption</p> <p>H1d. <input type="checkbox"/> Comatose</p> <p>H1e. <input type="checkbox"/> Persistent Vegetative State</p> <p>H1f. <input type="checkbox"/> Other</p> <p>H1g. Other (specify)</p> <p>H2. Enteral Nutrition Orders</p> <p>H2a. Strength of formula</p> <p>0) Full strength</p> <p>1) Half strength</p> <p>2) 3/4 strength</p> <p>H2b. Name of formula</p> <p>0) Jevity 1.2 Cal</p> <p>1) Jevity 1.5 Cal</p> <p>2) Osmolite 1.2 Cal</p> <p>3) Osmolite 1.5 Cal</p> <p>4) TwoCal HN</p> <p>5) Glucerna 1.2 Cal</p> <p>6) Nepro</p> <p>7) Suplena</p> <p>8) Promote with fiber</p> <p>9) Perative</p> <p>10) Pivot 1.5 Cal</p> <p>11) Vital AF 1.2 Cal</p> <p>12) Other</p> <p>H2c. If other type of formula (specify)</p> <p>H2d. Is a specialty enteral formula ordered?</p>

Patient Name: Robert Coker

Patient Number: 120915

H.

**Enteral
Nutrition
Orders**

- ☐ 0. No
☐ 1. Yes

H2e. If yes, indicate medical necessity for specialty enteral formula.

H3a. ☐ Pump, continuous

H3aa. If pump continuous, indicate # of ml per hour and # of hours (e.g., 50 ml/hr x 22 hrs)

H3b. ☐ Pump, cyclic/intermittent

H3bb. If pump cyclic/intermittent, indicate # of ml per hour, and start/stop time (e.g., 50 ml/hr from 7p to 7a)

H3c. ☐ Bolus (syringe)

H3cc. If bolus, indicate # of ml and the time of day or frequency (e.g., 240 ml at 9a, 1p, 5p, 9p, 1a, 5a)

H3d. ☐ Gravity bag

H3dd. If gravity, indicate # of ml and the time of day or frequency (e.g., 240 ml at 9a, 1p, 5p, 9p, 1a, 5a)

H3e. ☐ Modular enteral component

H3ee. If modular enteral component, indicate name, amount, frequency and method of administration (e.g., Propass, 1 scoop mixed with 30 ml water, 3 times per day via bolus)

Water flush

H4. Indicate ml of water and frequency (e.g., 200 ml every 4 hours and 30 ml before and after medication)

H.

**Enteral
Nutrition
Orders****H5. Indicate medical necessity of pump, if applicable:**

- H5a. ☐ Not applicable, pump not indicated
H5b. ☐ Severe diarrhea
H5c. ☐ Severe vomiting
H5d. ☐ Hx of aspiration pneumonia
H5e. ☐ J-tube
H5f. ☐ Dumping syndrome
H5g. ☐ Potential for circulatory overload d/t renal failure, heart failure/CHF
H5h. ☐ Reflux disease/GERD
H5i. ☐ Unstable diabetes
H5j. ☐ Other
H5k. If other specify:

H6. Enteral Access

- 0) NG tube
1) G-tube
2) J-tube
3) Other (specify)
H6a. If other enteral access (specify)

H7. Energy, Protein, Fluid from Enteral Nutrition

H7a. Volume from formula(s) mL/24hr

H7b. Water from formula(s) mL/24hr

H7c. Total water from flush mL/24hr

H7d. Total volume mL/24hr = volume from formula(s) + total water from flush

H7e. Total water mL/24hr = water from formula(s) + total water from flush

H7f. Water per kg body weight

H7g. % estimated water needs met by formula(s) and flush

H7h. Energy provided by formula(s) calories/24hr

H7i. Energy per kg body weight

H7j. % estimated energy needs met by formula(s)

H7k. Indicate medical necessity if less than 750 or more than 2000 calories are provided

Patient Name: Robert Coker

Patient Number: 13065

H.	Enteral Nutrition Orders	<p>H7l. Protein provided by formula(s) grams/24hr <input type="text"/></p> <p>H7m. Protein per kg body weight <input type="text"/></p> <p>H7n. % estimated protein needs met by formula(s) <input type="text"/></p> <p>H7o. % RDI for vitamins/minerals provided by formula(s) <input type="text"/></p> <p>8. Does the patient receive parenteral nutrition? If checked, refer to Parenteral Nutrition Worksheet for nutrient calculations. Please complete Questions A and B at the end of Section H. (K0700 of the MDS)</p> <p><input checked="" type="radio"/> 0. No</p> <p><input type="radio"/> 1. Yes</p> <p>K0700. Percent Intake by Artificial Route - Complete K0700 only if K0500A (Parenteral/IV feeding) or K0500B (Feeding tube) is checked</p> <p>A. Proportion of total calories the resident received through parenteral or tube feeding</p> <p><input type="radio"/> 1. 25% or less</p> <p><input type="radio"/> 2. 26-50%</p> <p><input type="radio"/> 3. 51% or more</p> <p><input checked="" type="radio"/> -. Not assessed</p> <p>B. Average fluid intake per day by IV or tube feeding</p> <p><input type="radio"/> 1. 500 cc/day or less</p> <p><input type="radio"/> 2. 501 cc/day or more</p> <p><input checked="" type="radio"/> -. Not assessed</p>
I.	Nutrition Diagnosis	<p>I1. Is there a nutrition diagnosis at this time</p> <p><input type="radio"/> 0. No</p> <p><input checked="" type="radio"/> 1. Yes</p> <p>I2. Nutrition diagnosis #1 (specify)</p>

I.	Nutrition Diagnosis	<p>0) Inadequate energy intake 1) Excessive energy intake 2) Predicted suboptimal energy intake 3) Predicted excessive energy intake 4) Inadequate oral intake 5) Excessive oral intake 6) Limited food acceptance 7) Less than optimal enteral nutrition 8) Less than optimal parenteral nutrition 9) Inadequate fluid intake 10) Inconsistent carbohydrate intake 11) Inadequate intake of calcium 12) Predicted suboptimal nutrient intake 13) Predicted excessive nutrient intake 14) Swallowing difficulty 15) Biting/Chewing (masticatory) difficulty 16) Underweight 17) Unintentional weight loss 18) Overweight/obesity 19) Unintentional weight gain 20) Food-and nutrition-related knowledge deficit 21) Not ready for diet/lifestyle change 22) Limited adherence to nutrition-related recommendations 23) Self-feeding difficulty 25) Increased Nutritional Needs 26) Malnutrition 27) Other(Specify. Refer to the International Dietetics & nutrition Terminology Reference Manual for standard terminology) I2a.If other diagnosis (specify)</p> <p>I2b.Related to: increased lethargy, swallowing problems</p> <p>I2c.As evidenced by: minimal p.o. intake</p> <p>I3. Nutrition Diagnosis #2 (specify)</p>
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I.	Nutrition Diagnosis	<ul style="list-style-type: none">0) Inadequate energy intake1) Excessive energy intake2) Predicted suboptimal energy intake3) Predicted excessive energy intake4) Inadequate oral intake5) Excessive oral intake6) Limited food acceptance7) Less than optimal enteral nutrition8) Less than optimal parenteral nutrition9) Inadequate fluid intake10) Inconsistent carbohydrate intake11) Inadequate intake of calcium12) Predicted suboptimal nutrient intake13) Predicted excessive nutrient intake14) Swallowing difficulty15) Biting/Chewing (masticatory) difficulty16) Underweight17) Unintentional weight loss18) Overweight/obesity19) Unintentional weight gain20) Food-and nutrition-related knowledge deficit21) Not ready for diet/lifestyle change22) Limited adherence to nutrition-related recommendations23) Self-feeding difficulty25) Increased Nutritional Needs26) Malnutrition27) Other(Specify. Refer to the International Dietetics & nutrition Terminology Reference Manual for standard terminology) <p>I3a.If other diagnosis (specify)</p> <p>I3b.Related to:</p> <p>I3c.As evidenced by:</p> <p>14. Nutrition diagnosis #3</p>
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J2f. ☐ Medical food supplement: commercial food

J.	Nutrition Intervention	<p>J2g. <input type="checkbox"/> Modified beverage</p> <p>J2h. <input type="checkbox"/> Modified food</p> <p>J2i. <input type="checkbox"/> Multivitamin/mineral</p> <p>J2j. <input type="checkbox"/> Vitamin: D</p> <p>J2k. <input type="checkbox"/> Mineral: Calcium</p> <p>J2l. <input type="checkbox"/> Mineral: Iron</p> <p>J2m. <input type="checkbox"/> Adaptive equipment</p> <p>J2n. <input type="checkbox"/> Nutrition education-content: recommended modifications</p> <p>J2o. <input type="checkbox"/> Nutrition education-application: skill development</p> <p>J2p. <input type="checkbox"/> Collaboration/referral to other providers</p> <p>J2q. <input type="checkbox"/> Other intervention</p> <p>J2r. Other (Specify. Refer to the International Dietetics & Nutrition Terminology Reference Manual for standard terminology)</p> <p>J3. Goals</p> <p>J3a. <input checked="" type="checkbox"/> Will consume adequate energy to maintain weight (specify)</p> <p>J3aa. Specify weight/weight range: 210-220#</p> <p>J3b. <input type="checkbox"/> Will consume adequate energy to gain weight (specify)</p> <p>J3bb. Specify amount of desired gain per month and goal weight</p> <p>J3c. <input type="checkbox"/> Will consume adequate energy to lose (specify)</p> <p>J3cc. Specify amount of desired loss per month and goal weight.</p> <p>J3d. <input checked="" type="checkbox"/> Will have an average meal intake of at least (specify)</p> <p>J3ee. Specify average meal intake. 50% initially</p> <p>J3f. <input checked="" type="checkbox"/> Other goal (specify)</p> <p>J3ff. Other (specify) no s/s of aspiration</p>
K.	Nutrition Monitoring and Evaluation	<p>Choose all that apply:</p> <p>1A. <input checked="" type="checkbox"/> Food/beverage intake</p> <p>1B. <input type="checkbox"/> Food intake</p> <p>1C. <input type="checkbox"/> Enteral nutrition intake</p> <p>1D. <input type="checkbox"/> Parenteral nutrition intake</p> <p>1E. <input type="checkbox"/> Eating environment</p> <p>1F. <input type="checkbox"/> Food and nutrition knowledge</p> <p>1G. <input type="checkbox"/> Readiness to change nutrition-related behaviors</p>

K.	Nutrition Monitoring and Evaluation	<p>1H. <input checked="" type="checkbox"/> Food preferences</p> <p>1I. <input type="checkbox"/> Self-management as agreed upon</p> <p>1J. <input type="checkbox"/> Mealtime behavior</p> <p>1K. <input type="checkbox"/> Nutrition related ADLs and IADLs</p> <p>1L. <input checked="" type="checkbox"/> Weight change</p> <p>1M. <input checked="" type="checkbox"/> Biochemical data: electrolyte and renal profile</p> <p>1N. <input checked="" type="checkbox"/> Biochemical data: glucose/endocrine profile</p> <p>1O. <input checked="" type="checkbox"/> Biochemical data: lipid profile</p> <p>1P. <input checked="" type="checkbox"/> Biochemical data: nutritional anemia profile</p> <p>1Q. <input checked="" type="checkbox"/> Biochemical data: protein profile</p> <p>1R. <input checked="" type="checkbox"/> Skin</p> <p>1S. <input type="checkbox"/> Other nutrition monitoring (specify)</p> <p>1T. If other (Specify. Refer to the International Dietetics & Nutrition Terminology Reference Manual for standard terminology)</p>
L.	Comments and Careplan Decision	<p>L1. Comments Patient consuming minimal food/fluids. Has received IVF's. Per patient's son, patient was eating well until discharge from the hospital-no hx of weight loss. Weight fluctuations possible, given Lasix tx. Followed by SLP and diet consistency downgraded to Pureed. Spoke with MD and suggested tube feeding be considered if patient alertness and p.o. intake do not improve in the next 2-3 days.</p> <p>L2. Careplan Decision <input checked="" type="radio"/> 0. Proceed to careplan <input type="radio"/> 1. Do not proceed to careplan</p> <p>L3. Rationale for careplan decision Decreased oral intake related to swallowing problems</p>

SIGNED

Signed By	Signed Date
Cheryl Gullickson, MS, RD, LD [ESOF]	10/19/2012

A.	Personal Information	<p>1. Person(s) providing info: <input type="text" value="Andy"/></p> <p>2. Relationship: <input type="text" value="Son"/></p> <p>3. Marital Status <input type="radio"/> 1. Never married <input checked="" type="radio"/> 2. Married <input type="radio"/> 3. Widowed <input type="radio"/> 4. Separated <input type="radio"/> 5. Divorced <input type="radio"/> - Not assessed</p> <p>4. Spouse Name: <input type="text" value="Ms. Coker"/></p> <p>5. Number of children: <input type="text" value="2"/></p> <p>6. Do children provide assistance? <input type="radio"/> 1. Yes <input checked="" type="radio"/> 2. No <input type="radio"/> 3. NA</p> <p>7. Describe frequency and type of assistance provided:</p> <p>8. Hearing: <input checked="" type="radio"/> 1. Adequate <input type="radio"/> 2. Minimal difficulty <input type="radio"/> 3. Moderate difficulty <input type="radio"/> 4. Highly impaired</p> <p>9. Hearing Aides used? <input type="radio"/> 1. Yes <input checked="" type="radio"/> 2. No</p> <p>10. Vision: <input type="radio"/> 1. Reads without glasses <input checked="" type="radio"/> 2. Wears glasses to read <input type="radio"/> 3. Wears glasses to see <input type="radio"/> 4. Highly impaired</p>
B.	Caregiver information	<p>1. Do you have a caregiver? <input checked="" type="radio"/> 1. Yes <input type="radio"/> 2. No</p> <p>2. Caregivers name / relationship: <input type="text" value="He lives in ALF"/></p> <p>3. Can caregiver lift you / provide physical support if necessary? <input checked="" type="radio"/> 1. Yes <input type="radio"/> 2. No</p> <p>4. Can we talk to your caregiver?</p>

B.	Caregiver information	<p><input checked="" type="radio"/> 1. Yes <input type="radio"/> 2. No</p> <p>5. Phone number of caregiver: <input type="text" value="7704610039"/></p> <p>6. Do you need a caregiver? <input type="radio"/> 1. Yes <input type="radio"/> 2. No</p>
C.	Discharge Information	<p>1. Where do you plan to go when discharged? <input type="radio"/> 1. House-one level <input type="radio"/> 2. House-two level <input type="radio"/> 3. Apartment <input checked="" type="radio"/> 4. Assisted Living <input type="radio"/> 5. LTC <input type="radio"/> 6. Other(specify)</p> <p>2. Comments on other housing:</p> <p>3. Number of steps to enter premises? <input type="text" value="0"/></p> <p>4. Which floor is your bedroom on? <input checked="" type="radio"/> 1. first floor <input type="radio"/> 2. second floor / basement</p> <p>5. Which floor is your bathroom on? <input checked="" type="radio"/> 1. first floor <input type="radio"/> 2. second floor / basement</p> <p>6. Comments-bedroom / bathroom:</p> <p>6a. Explain number of stairs to 2nd floor / basement:</p> <p>7. GOALS (check all that apply) 7a. <input type="checkbox"/> I am independent with steps. 7b. <input type="checkbox"/> I need to be able to negotiate steps / stairs.</p> <p>8. Steps/stairs(check all that apply) 8a. <input type="checkbox"/> Multiple steps 8b. <input type="checkbox"/> Multiple stairs 8c. <input checked="" type="checkbox"/> No steps / stairs</p>
D.	Functionality at Residence	<p>1. Mobility: Did you use any adaptive equipment at home? 1a. <input type="checkbox"/> Uses no devices 1b. <input type="checkbox"/> Cane</p>

D. Functionality at Residence

1c. ☒ Walker

1d. ☐ Scooter

1e. When did you start using?

1 year ago

2. Mobility Goals: (check all that apply)

2a. I prefer to be able to walk without a cane / walker.

☐ 1. Yes

☒ 2. No

2b. I need to use a device at all times for safety.

☐ 1. Cane

☒ 2. Walker

☐ 3. Both

2c. I need to use a device on uneven surfaces for safety.

☐ 1. Cane

☒ 2. Walker

☐ 3. Both

Prosthetic devices

3. Does patient use prosthetic devices?

☐ 1. Yes

☒ 2. No

3a. Type:

3b. Location:

3c. Describe assistance needed:

Prosthetic Goals:

3d. ☐ I need to be able to put on / take off prosthetic device.

3e. ☐ I need my caregiver to be able to put on / take off my prosthetic device.

Falls:

4a.

☒ 1. Yes

☐ 2. No

4b. Fall in the past 3 months?

☒ 1. Yes

☐ 2. No

4c. Fall in the past 6 months?

☒ 1. Yes

☐ 2. No

4d. Injuries / Describe

D.	Functionality at Residence	
E.	ADL Function	<p>How did you bathe at home?</p> <p>1. Bathing assistance:</p> <p><input type="radio"/> 1. Independent</p> <p><input checked="" type="radio"/> 2. Needs assistance</p> <p>1b. When was assistance started / Describe:</p> <p>1c. Bathing:</p> <p><input type="radio"/> 1. Tub</p> <p><input checked="" type="radio"/> 2. Shower</p> <p><input type="radio"/> 3. Sponge Bath</p> <p><input type="radio"/> 4. No preference</p> <p>2. Bathing preference:</p> <p><input type="radio"/> 1. Prefer a.m.</p> <p><input type="radio"/> 2. Prefer p.m.</p> <p><input checked="" type="radio"/> 3. No preference</p> <p>3. Bath/Shower equipment:</p> <p>3a. <input checked="" type="checkbox"/> Shower bench</p> <p>3b. <input checked="" type="checkbox"/> Removable shower head</p> <p>3c. <input type="checkbox"/> Other</p> <p>3d. Specify / describe other bathing equipment:</p> <p>4. Grab bars:</p> <p>4a. <input checked="" type="checkbox"/> Tub / shower</p> <p>4b. <input checked="" type="checkbox"/> Toilet</p> <p>4c. <input type="checkbox"/> Other</p> <p>4d. Describe other grab bars:</p> <p>5. Dressing / Grooming:</p> <p><input type="radio"/> 1. Independent</p> <p><input checked="" type="radio"/> 2. Needs assistance</p> <p>6. Goals for bathing / dressing / grooming:</p> <p>6a. <input type="checkbox"/> I need to be able to groom / dress / bathe independently.</p> <p>6b. <input checked="" type="checkbox"/> I need my caregiver to be able to assist me / perform grooming / dressing / bathing.</p>

Physician: WENDY GOZA

F. Continence/Toileting

How did you function at home?

1. Are you continent of urine?

☐ 1. Yes☒ 2. No

Incontinence products used:

1a. Briefs / pads used?

☒ 1. Yes☐ 2. No☐ 3. NA

1b. When are they used?

☐ 1. During the day☐ 2. At night☒ 3. All the time

1c. When Started:

2. Are you continent of stool?

☐ 1. Yes☒ 2. No

Incontinence products used:

2a. Briefs used?

☒ 1. Yes☐ 2. No☐ 3. NA

2b. When are they used?

☐ 1. During the day☐ 2. At night☒ 3. All the time

2c. When started:

3. Do you use a bedside commode at home?

☐ 1. Yes☒ 2. No

4. Goals for continence / toileting:

4a. ☐ I believe I can be continent again.4b. ☒ I will need assistance using the toilet.4c. ☐ I need to be independent with toileting.

G. Household activities

What were you able to do at home?

1. Housekeeping:

1a. ☐ Independent1b. ☒ Assistance

1c. When did you begin to require assistance?

G.	Household activities	<p>What were you able to do at home?</p> <p>2. Cooking:</p> <p>2a. <input type="checkbox"/> Independent</p> <p>2b. <input checked="" type="checkbox"/> Assistance</p> <p>2c. When did you begin to require assistance?</p> <p>3. Laundry</p> <p>3a. <input type="checkbox"/> Independent</p> <p>3b. <input checked="" type="checkbox"/> Assistance</p> <p>3c. When did you begin to require assistance?</p> <p>3d. Laundry location:</p> <p>4. Goals for household activities:</p> <p>4a. <input type="checkbox"/> I need to be independent with household activities.</p> <p>4b. <input checked="" type="checkbox"/> I have assistance with household activities.</p>
H.	Medication Management:	<p>What medications did you take at home?</p> <p>1. Medications / frequency / reasons for use: ALF assists with medications</p> <p>2. Goals for medication administration:</p> <p>2a. <input type="checkbox"/> I need to manage my medications without assistance.</p> <p>2b. <input type="checkbox"/> My caregiver must be trained to assist me with my medications.</p> <p>2c. <input checked="" type="checkbox"/> My caregiver must be trained to administer my medications.</p>
I.	Disease Management	<p>Diagnoses that affects function:</p> <p>1. Diagnoses:</p> <p>Goals:</p> <p>1b. <input type="checkbox"/> I need to manage my disease(s), understand how to identify change of condition.</p> <p>1c. <input type="checkbox"/> I need to understand when to alert my caregiver that my condition has changed.</p> <p>1d. <input checked="" type="checkbox"/> I need to have my caregiver manage my disease(s), identify change in condition.</p>

Physician: WENDY GOZA

J.	General Information:	<p>1. Have you been in a Nursing Home recently?</p> <p><input type="radio"/> 1. Yes</p> <p><input checked="" type="radio"/> 2. No</p> <p>1b. Where / When / How long?</p> <p>2. Did you reside somewhere other than your home?</p> <p><input checked="" type="radio"/> 1. Yes</p> <p><input type="radio"/> 2. No</p> <p>2a. Where / When / How long?</p> <p>ALF- Azalea Estates</p> <p>3. Were you in a hospital in the last year?</p> <p><input type="radio"/> 1. Yes</p> <p><input checked="" type="radio"/> 2. No</p> <p>3a. Where / When / How long?</p> <p>3b. Comments:</p>
K.	Version	Verion 1.0 April 2011

SIGNED

Signed By	Signed Date
Alicia Shaw, BS [ESOF]	10/19/2012

Location: 1-5 501 A

Admission Date: 10/16/2012

Date of Birth: 6/16/1927

Gender: M

Primary Language: NA

Physician: WENDY, GOZA

Allergies: PCN,CIPRO,BACTRIM,SULFA,CLINDAMYCIN

Title: PATIENT NURSING
EVALUATION PART 3

Type: Admission

Facility Name: Kindred Transitional Care
and Rehabilitation -
Lafayette - 1228Malnutrition Screening
Tool (MST) Score: 5.0Malnutrition Screening
Tool (MST) Category: MST - Risk for
Malnutrition

1. Type of Assessment

1.	Type of Assessment	1.	Type of Assessment
			<input checked="" type="radio"/> 0. Admission
			<input type="radio"/> 1. Readmission

O. Personal Habits

O.	Personal Habits	O1. Personal Habits - Check all that apply	Sleep Pattern
		1A. <input type="checkbox"/> Tobacco Use	2A. Rises at (enter time) <input type="text"/>
		1B. <input type="checkbox"/> Smokes	2B. Naps at (enter time) <input type="text"/>
		1C. <input type="checkbox"/> Alcohol Use	2C. Bedtime (enter time) <input type="text"/>
		1D. <input checked="" type="checkbox"/> None of the Above	

P. Self-Administration of Medication

P.	Self-Administration of Medication	P1. Patient desires to self medicate:
		<input checked="" type="radio"/> 0. No
		<input type="radio"/> 1. Yes

Q. Mental Health

Q.	Neurological/Mental Health	Q1. Behaviors (Check all that apply)	Q2. Mood (Check all that apply)
		1A. <input type="checkbox"/> Wandering	2A. <input type="checkbox"/> Calm
		1B. <input type="checkbox"/> Resists care	2B. <input type="checkbox"/> Weeping/Crying
		1C. <input type="checkbox"/> Verbal Abuse	2C. <input type="checkbox"/> Agitated
		1D. <input type="checkbox"/> Sexually Inappropriate	2D. <input checked="" type="checkbox"/> Restless
		1E. <input type="checkbox"/> Physical Abuse	3E. <input type="checkbox"/> Angry
		1F. <input checked="" type="checkbox"/> None of the Above	2F. <input type="checkbox"/> Worried
			2G. <input type="checkbox"/> Hopeless
			2H. <input type="checkbox"/> Tired/No energy
			Q3. On Antipsychotic Medication <input type="radio"/> 0. No <input type="radio"/> 1. Yes

R. Eyes/Vision

R.	Eyes/Vision	R1. Pupils equal and reactive to light
		<input type="radio"/> 0. No <input checked="" type="radio"/> 1. Yes
		R2. If not - describe pupil size and reaction
		R3. Vision adequate with correction
		<input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes
		R4. Blind

R.	Eyes/Vision
	<input checked="" type="radio"/> a. N/A <input type="radio"/> b. (L) Eye <input type="radio"/> c. (R) Eye <input type="radio"/> d. Both eyes
R5.	Cataracts
	<input checked="" type="radio"/> a. N/A <input type="radio"/> b. (L) Eye <input type="radio"/> c. (R) Eye <input type="radio"/> d. Both eyes
R6.	Corrective Lenses: Contact Lenses
	<input checked="" type="radio"/> a. N/A <input type="radio"/> b. (L) Eye <input type="radio"/> c. (R) Eye <input type="radio"/> d. Both eyes
R7.	Corrective Lenses: Glasses
	<input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes
R8.	Eye Prosthesis/ Glass Eye
	<input checked="" type="radio"/> a. N/A <input type="radio"/> b. (L) Eye <input type="radio"/> c. (R) Eye <input type="radio"/> d. Both eyes
R9.	Other - Specify

S. Ears/Hearing

S.	Ears/Hearing	
	S1.	Hears adequately <input type="radio"/> 0. No <input checked="" type="radio"/> 1. Yes
	S2.	Hard of hearing <input checked="" type="radio"/> a. N/A <input type="radio"/> b. (L) Ear <input type="radio"/> c. (R) Ear <input type="radio"/> d. Both Ears
	S3.	Ringing in ears <input checked="" type="radio"/> a. N/A <input type="radio"/> b. (L) Ear <input type="radio"/> c. (R) Ear <input type="radio"/> d. Both Ears
	S4.	Other hearing issues or complaints
	S5.	Hearing aides <input checked="" type="radio"/> a. N/A <input type="radio"/> b. (L) Ear <input type="radio"/> c. (R) Ear <input type="radio"/> d. Both Ears
	S6.	Other hearing devices

T. Communication

T.	Communication	<p>T1. Ability to express ideas and wants, consider both verbal and non-verbal expression</p> <ul style="list-style-type: none"> <input checked="" type="radio"/> 0. Understood <input type="radio"/> 1. Usually understood <input type="radio"/> 2. Sometimes understood <input type="radio"/> 3. Rarely/never understood <input type="radio"/> -. Not assessed <p>T2. Understanding verbal content, however able (with hearing aid or device if used)</p> <ul style="list-style-type: none"> <input checked="" type="radio"/> 0. Understands <input type="radio"/> 1. Usually understands <input type="radio"/> 2. Sometimes understands <input type="radio"/> 3. Rarely/never understands <input type="radio"/> -. Not assessed <p>T3. Select best description of speech pattern</p>
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T.	Communication	<input checked="" type="radio"/> 0. Clear speech
		<input type="radio"/> 1. Unclear speech
		<input type="radio"/> 2. No speech
		<input type="radio"/> - Not assessed
		T4. Speaks English?
		<input checked="" type="radio"/> 1. Yes
T5.	Dominant Language	
T6.	Communication Devices	

U. Oral/Mouth

U.	Oral/Mouth	U1. Oral Health (Check all that apply)
		1A. <input checked="" type="checkbox"/> Oral mucosa moist, pink, without lesions or ulcerations, good oral hygiene
		1B. <input type="checkbox"/> Oral Discomfort/Pain
		1C. <input type="checkbox"/> Caries/Decay
		1D. <input type="checkbox"/> Candida
		1E. <input type="checkbox"/> Inflamed/Bleeding Gums
		1F. <input type="checkbox"/> Ulcers/Lesions
		1G. <input type="checkbox"/> Missing Teeth
		1H. <input type="checkbox"/> Edentulous/No natural teeth/ Tooth Fragments
		U2. Does patient have partial dentures?
		<input type="radio"/> 0. No <input checked="" type="radio"/> 1. Yes
		Upper Partial Denture:
		2A. <input type="checkbox"/> Fit
		2B. <input type="checkbox"/> Loose/ill fitting
		2C. <input type="checkbox"/> Broken/Chipped
		Lower Partial Denture:
		2D. <input type="checkbox"/> Fit
		2E. <input checked="" type="checkbox"/> Loose/ill Fitting
		2F. <input type="checkbox"/> Broken/Chipped
		U3. Does the patient have full plate dentures?
		<input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes
		Full Upper Plate
		3A. <input type="checkbox"/> Fit
		3B. <input type="checkbox"/> Loose/ill Fitting
3C. <input type="checkbox"/> Broken/Chipped		
Lower Full Plate		
3D. <input type="checkbox"/> Fit		
3E. <input type="checkbox"/> Loose/ill Fitting		
3F. <input type="checkbox"/> Broken/Chipped		
U4. Does patient have any of the following oral/mouth problems?		

Title: PATIENT NURSING
EVALUATION PART 3

W. Respiratory/Lung Function		
W.	Respiratory/Lung Function	<p>W1. Airway patent, normal breath sounds, no chest deformity, no bulging or intercostal retraction?</p> <p><input type="radio"/> 0. No</p> <p><input checked="" type="radio"/> 1. Yes</p> <p>If no - check all that apply</p> <p>1A. <input type="checkbox"/> Productive cough</p> <p>1B. <input type="checkbox"/> Wheezing</p> <p>1C. <input type="checkbox"/> Crackles</p> <p>1D. <input type="checkbox"/> Hemoptysis</p> <p>1E. <input type="checkbox"/> Orthopnea</p> <p>1F. <input type="checkbox"/> Nasal Discharge</p> <p>1G. <input type="checkbox"/> Rhonchi</p> <p>1H. <input type="checkbox"/> Short of air on exertion</p> <p>1I. <input type="checkbox"/> Congestion</p> <p>1J. <input type="checkbox"/> Cyanosis</p> <p>1K. <input type="checkbox"/> Increased secretions requiring suction</p> <p>1L. <input type="checkbox"/> Pursed Lips</p> <p>1M. <input type="checkbox"/> Using Accessory Muscles</p> <p>1N. <input type="checkbox"/> Short of air on rest</p> <p>W2. Is patient using any of the following (O2, Trach, CPaP, BiPaP, Nebulizer) for respiratory assistance?</p> <p><input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes</p> <p>If yes - check all that apply</p> <p>2A. <input type="checkbox"/> Oxygen</p> <p>2A1. Liters of O2 per min</p> <p><input type="checkbox"/></p>

Location: 1-5 501 A

Physician: WENDY GOZA

Title: PATIENT NURSING
EVALUATION PART 3

W.	Respiratory/Lung Function	Method of Delivery
		2A2. Nasal Cannula
		<input type="radio"/> 0. Nasal Cannula <input type="radio"/> 1. Face Mask <input type="radio"/> 2. Trach Mask
		2B. <input type="checkbox"/> Tracheostomy
		2C. <input type="checkbox"/> CPaP
		2D. <input type="checkbox"/> BiPaP
		2E. <input type="checkbox"/> Nebulizer Therapy
		W3. If on oxygen or has a tracheostomy, CPaP, BiPaP, Nebulizer Therapy or require suction - baseline O2 Sat on room air is <input type="checkbox"/>
		W4. If on oxygen or has a tracheostomy, CPaP, BiPaP, Nebulizer Therapy or require suction - baseline O2 Sat on oxygen is <input type="checkbox"/>
		W5. Does the patient compensate for shortness of breath by limiting activity, raising the head of their bed?
<input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes		
W6. Does the patient have difficulty lying flat?		
<input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes		
W7. In the last 30 days, has there been a change in breathing?		
<input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes		
7A. If yes - describe the change		

X. Gastrointestinal

X.	Gastrointestinal	X1. Abdomen is normal, soft, slightly rounded(in non-obese), bowel sounds in all 4 quadrants, umbilicus not herniated
		<input type="radio"/> 0. No <input checked="" type="radio"/> 1. Yes
		If no - check all that apply
		1A. <input type="checkbox"/> Rebound Tenderness
		1B. <input type="checkbox"/> Abdomen hard/rigid
		1C. <input type="checkbox"/> Bowel sounds absent in right upper quadrant
		1D. <input type="checkbox"/> Bowel sounds absent in left upper quadrant
		1E. <input type="checkbox"/> Bowel sounds absent in right lower quadrant
		1F. <input type="checkbox"/> Bowel sounds absent in left lower quadrant
		1G. <input type="checkbox"/> Bowel sounds sluggish
1H. <input type="checkbox"/> Bowel sounds hyperactive		

Y. Activities of Daily Living

Y1.	Activities of Daily Living	Prior Level of Function in the last 30 Days
		Y1. Ambulation
		<input type="radio"/> 0. Independent
		<input type="radio"/> 1. Set-Up Assistance Only
		<input type="radio"/> 2. Limited Assist
		<input checked="" type="radio"/> 3. Extensive Assist
Y2. Does the patient use assistive devices for ambulation		
<input type="radio"/> 0. No <input checked="" type="radio"/> 1. Yes		
If yes - check all that apply		
2A. <input type="checkbox"/> Cane		

Y1.	Activities of Daily Living	Prior Level of Function in the last 30 Days
		2B. <input checked="" type="checkbox"/> Walker
		2C. <input type="checkbox"/> Scooter
		2D. <input type="checkbox"/> Prosthetic devices
		2D1. List prosthetic devices used
		Y3. Transfer
		<input type="radio"/> 0. Independent
		<input type="radio"/> 1. Set-up assistance only
		<input type="radio"/> 2. Limited Assist
		<input checked="" type="radio"/> 3. Extensive Assist
		<input type="radio"/> 4. Dependent
		<input type="radio"/> 5. Mechanical Lift
		Y4. Dressing
		<input type="radio"/> 0. Independent
		<input type="radio"/> 1. Set-Up assistance only
		<input type="radio"/> 2. Limited Assist
		<input checked="" type="radio"/> 3. Extensive Assist
		<input type="radio"/> 4. Dependent
		Y5. Eating
		<input type="radio"/> 0. Independent
		<input type="radio"/> 1. Set-Up assistance only
		<input type="radio"/> 2. Limited Assist
		<input checked="" type="radio"/> 3. Extensive Assist
		<input type="radio"/> 4. Dependent
		Y6. Bathing
		<input type="radio"/> 0. Independent
		<input type="radio"/> 1. Supervision
		<input type="radio"/> 2. Physical Help - Transfer Only
		<input type="radio"/> 3. Physical Help in part of bathing activity
		<input checked="" type="radio"/> 4. Dependent
		Y7. Bathing Type and Time Preference - check all that apply
		7A. <input type="checkbox"/> Tub
		7B. <input type="checkbox"/> Shower
		7C. <input checked="" type="checkbox"/> Sponge Bath
		7D. <input type="checkbox"/> Bathe in AM
		7E. <input type="checkbox"/> Bathe in PM

Z. Bladder Status Screening

Z.	Bladder Status Screening	Z1. Urinary continence - Select the one category that best describes the resident
		<input type="radio"/> 0. Always continent
		<input type="radio"/> 1. Occasionally incontinent
		<input checked="" type="radio"/> 2. Frequently incontinent
		<input type="radio"/> 3. Always incontinent
		<input type="radio"/> 9. Not rated
		<input type="radio"/> -. Not assessed

Z. Bladder Status Screening

Z2. What is your normal daily routine to go to the bathroom?

2A. ☐ Upon Rising

2B. ☐ After Meals

2C. ☐ Before Bedtime

2D. ☒ No apparant pattern

Z3. How often do you usually need to use the bathroom during the day?

Z4. Check all that apply

- 4A. ☒ Physically reliant on care giver to go to the bathroom
- 4B. ☐ Unable to indicate toileting needs
- 4C. ☒ Wears/needs briefs/protective underwear/tissue for protection
- 4E. ☐ Urge to toilet interrupts sleep
- 4D. ☐ Nocturia
- 4F. ☐ Constant sensation to urinate
- 4G. ☐ Difficulty to hold off going to the bathroom for 2 hours
- 4H. ☐ Dribbles when coughing/sneezing
- 4I. ☐ Feels urgency when needing to go to the bathroom
- 4J. ☐ Difficulty starting stream
- 4K. ☐ Pain/Burning upon urination
- 4L. ☐ Blood in urine
- 4M. ☐ Bladder distention
- 4N. ☐ Incontinence recent onset
- 4O. ☐ Current bladder toileting program

Z5. Is the patient able to participate in a bladder toileting program?

- ☐ 0. No
- ☒ 1. Yes
- ☐ 2. Not applicable

Indwelling Urinary Devices

Z6. Indwelling Catheter

- ☒ 0. No
- ☐ 1. Yes

6A. Size of Indwelling Catheter

6B. Justification

Z7. Intermittent Catheterization

- ☒ 0. No
- ☐ 1. Yes

7A. Rationale for intermittent catheterization

Z.

Bladder Status Screening

Z8. Suprapubic Catheter

☐ 0. No

☐ 1. Yes

8A. Rationale for suprapubic catheter

Z9. Other Indwelling Urinary Devices - specify

AA. Bowel Status Screening

AA.

Bowel Status Screening

AA1.Date of Last Bowel Movement
11/1/2018

10/15/2012

AA2.Bowel continence - Select the one category that best describes the resident

0. Always continent

☒ 1. Occasionally incontinent

☐ 2. Frequently incontinent

3. Always incontinent

9. Not rated

- Not assessed

AA3.Change in bowel function

☐ 0. No

☐ 1. Yes

AA4. Check All that apply

4A. ☒ Physically reliant on care giver to go to the bathroom

4B. ☐ Constipation

4C. ☐ Uses stool softeners/laxatives

4D. ☐ No sensation of need to have BM

4E. ☐ Has a soiling problem

4F. ☐ On a current toileting program

4G. ☐ Food/Beverages affect bowels

4H. ☐ Colostomy

41. ☐ Ileostomy

4J. ☐ Sigmoidostomy

4K. ☐ None of the Above

AA5. If patient has ostomy - does the patient need assistance with care of the ostomy?

☐ 0. No

☒ 1. Yes

AA6. Patient stool consistency is usually

Effective Date: 10/16/2012 19:05

Location: 1-5 501 A

Physician: WENDY GOZA

Title: PATIENT NURSING
EVALUATION PART 3

AA.	Bowel Status Screening	<input checked="" type="radio"/> 0. Soft and Formed <input type="radio"/> 1. Small/Dry <input type="radio"/> 2. Hard and Formed <input type="radio"/> 3. Liquid
	AA7.	How often does the patient have a bowel movement?
	AA8.	Is patient able to participate in a bowel toileting program? <input type="radio"/> 0. No <input checked="" type="radio"/> 1. Yes <input type="radio"/> 2. Not applicable

BB. Malnutrition Screening Tool (MST)

BB.	Malnutrition Screening Tool (MST)	<p>BB1. Have you lost weight without trying?</p> <p><input type="radio"/> 0. No</p> <p><input type="radio"/> 1. Yes</p> <p><input checked="" type="radio"/> 2. Unsure</p> <p>BB2. If yes - weight in pounds you have lost</p> <p><input type="radio"/> 0. 2-10 lbs</p> <p><input type="radio"/> 1. 11-20 lbs</p> <p><input type="radio"/> 2. 21-30 lbs</p> <p><input type="radio"/> 3. Greater than 30 lbs</p> <p><input checked="" type="radio"/> 4. Unsure</p> <p>2A. Time frame for weight loss</p> <p>BB3. Have you been eating poorly because of a decreased appetite?</p> <p><input type="radio"/> 0. No</p> <p><input checked="" type="radio"/> 1. Yes</p>
-----	-----------------------------------	---

CC. Total Parenteral Nutrition (TPN)

CC.	Total Parenteral Nutrition (TPN)	CC1.	Is the patient on TPN? <input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes
-----	----------------------------------	------	--

DD, Intravenous Therapy

DD.	Intravenous Therapy	DD1.Has an IV <input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes DD2 Type of IV access 2A. <input type="checkbox"/> IV PICC 2B. <input type="checkbox"/> IV Central 2C. <input type="checkbox"/> IV Midline 2D. <input type="checkbox"/> IV Port DD3.IV site/location
-----	---------------------	---

DD.	Intravenous Therapy	<p>DD4.Reason for IV:</p> <p>DD5.IV access patent? <input type="radio"/> 0. No <input type="radio"/> 1. Yes</p> <p>5A. If no - list interventions</p> <p>DD6. IV Site</p> <p>6A. <input type="checkbox"/> Clear, no redness or swelling</p> <p>6B. <input type="checkbox"/> Surrounding skin red</p> <p>6C. <input type="checkbox"/> Tender</p> <p>6D. <input type="checkbox"/> Swollen</p> <p>6E. <input type="checkbox"/> Weeping</p>
-----	---------------------	---

EE. Tube Feeding

EE.	Tube Feeding	<p>EE1.Is patient on a tube feeding? <input type="radio"/> 0. No <input type="radio"/> 1. Yes</p> <p>EE2. Type of tube:</p> <p>2A. <input type="checkbox"/> Nasal Gastric (NG)</p> <p>2B. <input type="checkbox"/> Gastric Tube (GT)</p> <p>2C. <input type="checkbox"/> Peg Tube</p> <p>2D. <input type="checkbox"/> J-Tube (JT)</p> <p>2E. <input type="checkbox"/> Low Profile Gastric Tube</p> <p>EE3. Delivery Method</p> <p>3A. <input type="checkbox"/> Bolus</p> <p>3B. <input type="checkbox"/> Gravity</p> <p>3C. <input type="checkbox"/> Pump</p> <p>EE4.If pump used, list justification</p>
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FF. Tuberculosis Screening

FF.	Tuberculosis Screening	<p>FF1.Tuberculosis Screening - check all that apply</p> <p>1A. <input type="checkbox"/> Negative TST</p> <p>1B. <input type="checkbox"/> Positive Reactor to TST</p> <p>1C. <input type="checkbox"/> Chest X-Ray clear with no signs of active disease</p>
-----	------------------------	---

Patient Name: Robert Coker

Patient Number: 123965

Effective Date: 10/16/2012 19:05

Location: 1-5 501 A

Physician: WENDY GOZA

Title: PATIENT NURSING
EVALUATION PART 3

FF.	Tuberculosis Screening	1D. <input type="checkbox"/> History of Resolved TB FF2. Does the patient have signs and/or symptoms of TB? If yes, indicate below: <input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes 2A. <input type="checkbox"/> Has a productive cough lasting more than 2 weeks 2B. <input type="checkbox"/> Has been coughing up sputum for one week or more 2C. <input type="checkbox"/> Blood in sputum 2D. <input type="checkbox"/> Has experienced chronic fatigue for more than 2 weeks in duration 2E. <input type="checkbox"/> Experiencing night sweats 2F. <input type="checkbox"/> Recently converted to a positive TST 2G. <input type="checkbox"/> Has a weight loss of 8 pounds or more 2H. <input type="checkbox"/> Lost appetite 2I. <input type="checkbox"/> Reacting to a newly placed TST with no history of a positive TST
-----	------------------------	--

GG. Functional Impairment of Range of Motion

GG.	Functional Impairment of Range of Motion	GG1. Upper extremity (shoulder, elbow, wrist, hand) <input checked="" type="radio"/> 0. No impairment <input type="radio"/> 1. Impairment on one side <input type="radio"/> 2. Impairment on both sides <input type="radio"/> -. Not assessed GG2. Lower extremity (hip, knee, ankle, foot) <input type="radio"/> 0. No impairment <input checked="" type="radio"/> 1. Impairment on one side <input type="radio"/> 2. Impairment on both sides <input type="radio"/> -. Not assessed
-----	--	--

HH. Restraints

HH.	Restraints	HH1. Does the patient have a physician's order for a restraint? <input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes HH2. Is the patient restrained? <input checked="" type="radio"/> 0. No <input type="radio"/> 1. Yes
-----	------------	--

JJ. Summary

JJ.	Summary	Summary: JJ1.
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SIGNED SECTIONS

Signed By	Sections	Signed Date
Jennifer Smith-Franklin, LPN [ESOF]	1, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, HH, JJ	10/16/2012

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home PPS (NP) Item Set

Section A		Identification Information									
A0050. Type of Record											
Enter Code		1. Add new record → Continue to A0100, Facility Provider Numbers 2. Modify existing record → Continue to A0100, Facility Provider Numbers 3. Inactivate existing record → Skip to X0150, Type of Provider									
1											
A0100. Facility Provider Numbers											
		A. National Provider Identifier (NPI): 1 7 4 0 3 6 8 6 1 2									
		B. CMS Certification Number (CCN): 1 1 5 3 6 0									
		C. State Provider Number: 0 0 3 9 9 7 3 7 A									
A0200. Type of Provider											
Enter Code		Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed									
1											
A0310. Type of Assessment											
Enter Code		A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above									
9 9											
Enter Code		B. PPS Assessment <u>PPS Scheduled Assessments for a Medicare Part A Stay</u> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment <u>PPS Unscheduled Assessments for a Medicare Part A Stay</u> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <u>Not PPS Assessment</u> 99. None of the above									
0 1											
Enter Code		C. PPS Other Medicare Required Assessment - OMRA 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment									
0											
Enter Code		D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2 0. No 1. Yes									
A0310 continued on next page											

Section A Identification Information

A0310. Type of Assessment - Continued

Enter Code **E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry?**
 0. No
 1. Yes

Enter Code **F. Entry/discharge reporting**
 01. Entry tracking record
 10. Discharge assessment-return not anticipated
 11. Discharge assessment-return anticipated
 12. Death in facility tracking record
 99. None of the above

Enter Code **G. Type of discharge - Complete only if A0310F = 10 or 11**
 1. Planned
 2. Unplanned

A0410. Submission Requirement

Enter Code **1. Neither federal nor state required submission**
2. State but not federal required submission (FOR NURSING HOMES ONLY)
3. Federal required submission

A0500. Legal Name of Resident

A. First name:

B. Middle initial:

C. Last name:

D. Suffix:

A0600. Social Security and Medicare Numbers

A. Social Security Number: - -

B. Medicare number (or comparable railroad insurance number):

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

A0800. Gender

Enter Code **1. Male**
2. Female

A0900. Birth Date

- -
 Month Day Year

A1000. Race/Ethnicity

↓ Check all that apply

☐ **A. American Indian or Alaska Native**

☐ **B. Asian**

☐ **C. Black or African American**

☐ **D. Hispanic or Latino**

☐ **E. Native Hawaiian or Other Pacific Islander**

☐ **F. White**

Section A Identification Information**A1550. Conditions Related to ID/DD Status**

If the resident is 22 years of age or older, complete only if A0310A = 01

If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ Check all conditions that are related to ID/DD status that were manifested before age 22, and are likely to continue indefinitely

- ☐ ID/DD With Organic Condition
- ☐ A. Down syndrome
- ☐ B. Autism
- ☐ C. Epilepsy
- ☐ D. Other organic condition related to ID/DD
- ☐ ID/DD Without Organic Condition
- ☐ E. ID/DD with no organic condition
- ☐ No ID/DD
- ☐ Z. None of the above

A1600. Entry Date (date of this admission/entry or reentry into the facility)

1	0	-	1	6	-	2	0	1	2
Month		Day		Year					

A1700. Type of Entry

Enter Code

1

1. Admission
2. Reentry

A1800. Entered From

Enter Code

0 3

01. Community (private home/apt., board/care, assisted living, group home)
02. Another nursing home or swing bed
03. Acute hospital
04. Psychiatric hospital
05. Inpatient rehabilitation facility
06. ID/DD facility
07. Hospice
09. Long Term Care Hospital (LTCH)
99. Other

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

1	0	-	1	9	-	2	0	1	2
Month		Day		Year					

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

0 3

01. Community (private home/apt., board/care, assisted living, group home)
02. Another nursing home or swing bed
03. Acute hospital
04. Psychiatric hospital
05. Inpatient rehabilitation facility
06. ID/DD facility
07. Hospice
08. Deceased
09. Long Term Care Hospital (LTCH)
99. Other

Section A Identification Information	
A2200. Previous Assessment Reference Date for Significant Correction Complete only if A0310A = 05 or 06	
	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>
A2300. Assessment Reference Date	
	Observation end date: <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">0</div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">9</div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>
A2400. Medicare Stay	
Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin: 5px auto;">1</div>	<p>A. Has the resident had a Medicare-covered stay since the most recent entry?</p> <p>0. No → Skip to B0100, Comatose</p> <p>1. Yes → Continue to A2400B, Start date of most recent Medicare stay</p> <p>B. Start date of most recent Medicare stay:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">0</div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">6</div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div> <p>C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">0</div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">9</div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>

Look back period for all items is 7 days unless another time frame is indicated

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code **Persistent vegetative state/no discernible consciousness**
 0. No → Continue to B0200, Hearing
 1. Yes → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0200. Hearing

Enter Code **Ability to hear** (with hearing aid or hearing appliances if normally used)
 0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
 1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
 2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
 3. **Highly impaired** - absence of useful hearing

B0300. Hearing Aid

Enter Code **Hearing aid or other hearing appliance used** in completing B0200, Hearing
 0. No
 1. Yes

B0600. Speech Clarity

Enter Code **Select best description of speech pattern**
 0. **Clear speech** - distinct intelligible words
 1. **Unclear speech** - slurred or mumbled words
 2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code **Ability to express ideas and wants**, consider both verbal and non-verbal expression
 0. **Understood**
 1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
 2. **Sometimes understood** - ability is limited to making concrete requests
 3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code **Understanding verbal content, however able** (with hearing aid or device if used)
 0. **Understands** - clear comprehension
 1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
 2. **Sometimes understands** - responds adequately to simple, direct communication only
 3. **Rarely/never understands**

B1000. Vision

Enter Code **Ability to see in adequate light** (with glasses or other visual appliances)
 0. **Adequate** - sees fine detail, such as regular print in newspapers/books
 1. **Impaired** - sees large print, but not regular print in newspapers/books
 2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
 3. **Highly impaired** - object identification in question, but eyes appear to follow objects
 4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1200. Corrective Lenses

Enter Code **Corrective lenses (contacts, glasses, or magnifying glass) used** in completing B1000, Vision
 0. No
 1. Yes

Section C**Cognitive Patterns****C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?**

Attempt to conduct interview with all residents

Enter Code

0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)**C0200. Repetition of Three Words**

Enter Code

Ask resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: **sock, blue, and bed**. Now tell me the three words."

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code

Ask resident: "Please tell me what year it is right now."

A. Able to report correct year

0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code

Ask resident: "What month are we in right now?"

B. Able to report correct month

0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code

Ask resident: "What day of the week is today?"

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Enter Code

Ask resident: "Let's go back to an earlier question. What were those three words that I asked you to repeat?"

If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock"

0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code

B. Able to recall "blue"

0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code

C. Able to recall "bed"

0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)

Enter 99 if the resident was unable to complete the interview

Resident **Coker, Robert**Identifier **123965**Date **Oct 19, 2012****Section C****Cognitive Patterns****C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?**

Enter Code

1

0. No (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
 1. Yes (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code

1

- Seems or appears to recall after 5 minutes
 0. Memory OK
 1. Memory problem

C0800. Long-term Memory OK

Enter Code

1

- Seems or appears to recall long past
 0. Memory OK
 1. Memory problem

C0900. Memory/Recall Ability

↓ Check all that the resident was normally able to recall

- ☐ A. Current season
☐ B. Location of own room
☐ C. Staff names and faces
☐ D. That he or she is in a nursing home
☒ Z. None of the above were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code

2

- Made decisions regarding tasks of daily life
 0. **Independent** - decisions consistent/reasonable
 1. **Modified independence** - some difficulty in new situations only
 2. **Moderately impaired** - decisions poor; cues/supervision required
 3. **Severely impaired** - never/rarely made decisions

Delirium**C1300. Signs and Symptoms of Delirium (from CAM©)**

Code after completing Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

↓ Enter Codes in Boxes	
Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)	<input type="text" value="0"/> A. Inattention - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
	<input type="text" value="0"/> B. Disorganized thinking - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	<input type="text" value="0"/> C. Altered level of consciousness - Did the resident have altered level of consciousness (e.g., vigilant - startled easily to any sound or touch; lethargic - repeatedly dozed off when being asked questions, but responded to voice or touch; stuporous - very difficult to arouse and keep aroused for the interview; comatose - could not be aroused)?
	<input type="text" value="0"/> D. Psychomotor retardation - Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

C1600. Acute Onset Mental Status Change

Enter Code

0

- Is there evidence of an acute change in mental status from the resident's baseline?
 0. No
 1. Yes

Section D

Mood

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: **"Over the last 2 weeks, have you been bothered by any of the following problems?"**

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

If yes in column 1, then ask the resident: **"About how often have you been bothered by this?"**

Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence

0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency

0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

A. **Little interest or pleasure in doing things**

B. **Feeling down, depressed, or hopeless**

C. **Trouble falling or staying asleep, or sleeping too much**

D. **Feeling tired or having little energy**

E. **Poor appetite or overeating**

F. **Feeling bad about yourself - or that you are a failure or have let yourself or your family down**

G. **Trouble concentrating on things, such as reading the newspaper or watching television**

H. **Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual**

I. **Thoughts that you would be better off dead, or of hurting yourself in some way**

1. Symptom Presence	2. Symptom Frequency
↓ Enter Scores in Boxes ↓	
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

D0300. Total Severity Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

D0350. Safety Notification - Complete only if D0200I = 1 indicating possibility of resident self harm

Enter Code

Was responsible staff or provider informed that there is a potential for resident self harm?

0. **No**

1. **Yes**

Section D**Mood****D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)**

Do not conduct if Resident Mood Interview (D0200-D0300) was completed.

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. Symptom Presence

0. No (enter 0 in column 2)
1. Yes (enter 0-3 in column 2)

2. Symptom Frequency

0. Never or 1 day
1. 2-6 days (several days)
2. 7-11 days (half or more of the days)
3. 12-14 days (nearly every day)

A. Little interest or pleasure in doing things

B. Feeling or appearing down, depressed, or hopeless

C. Trouble falling or staying asleep, or sleeping too much

D. Feeling tired or having little energy

E. Poor appetite or overeating

F. Indicating that s/he feels bad about self, is a failure, or has let self or family down

G. Trouble concentrating on things, such as reading the newspaper or watching television

H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual

I. States that life isn't worth living, wishes for death, or attempts to harm self

J. Being short-tempered, easily annoyed

1. Symptom Presence	2. Symptom Frequency
↓ Enter Scores in Boxes ↓	
0	0
0	0
1	1
1	1
1	1
0	0
0	0
1	1
0	0
1	1

D0600. Total Severity Score

0 5

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code ☐ Was responsible staff or provider informed that there is a potential for resident self harm?

0. No
1. Yes